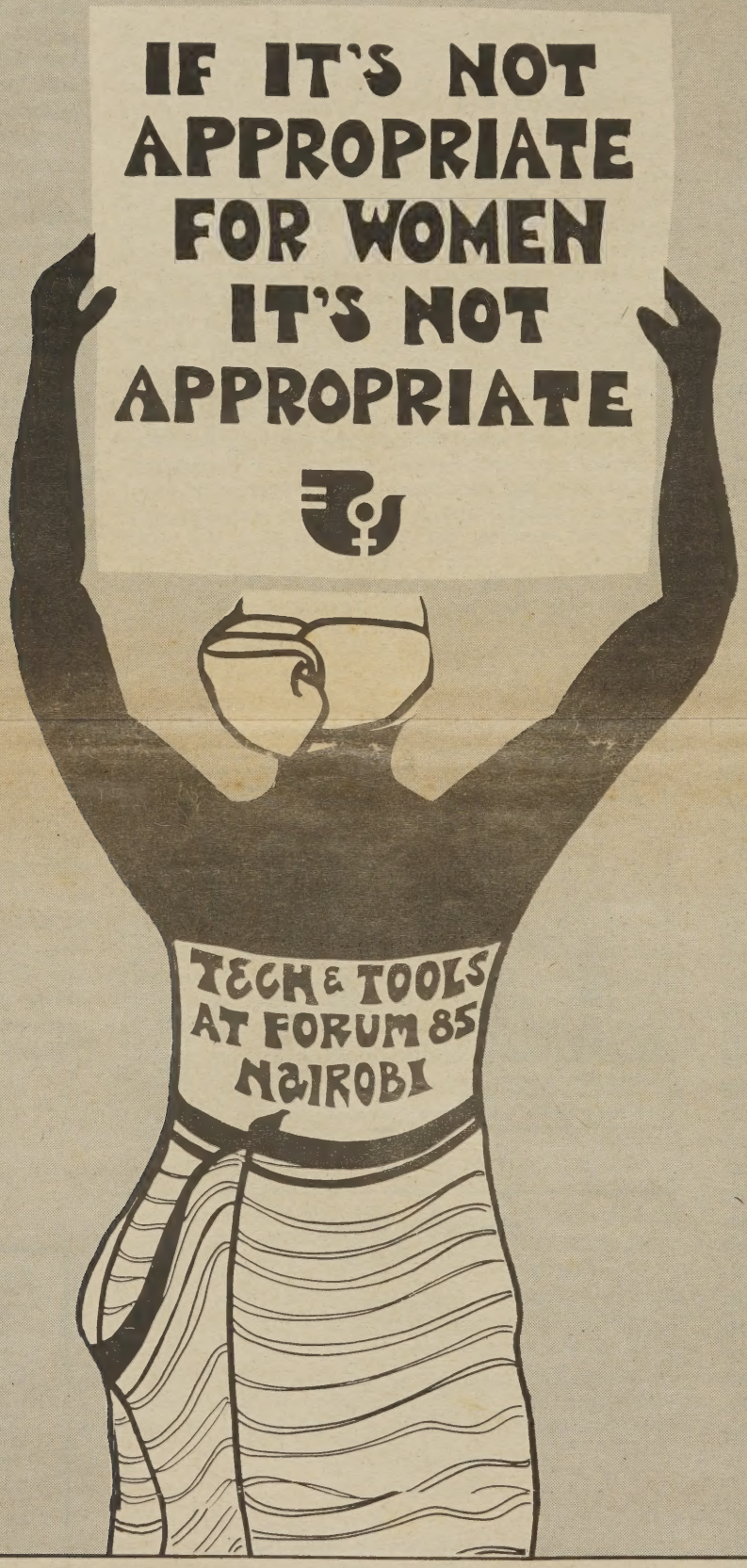
FORUM '85

NAIROBI • KENYA

vital signs

NEWS FROM THE NATIONAL BLACK WOMEN'S HEALTH PROJECT
VOLUME 3 NO. 1 January/1986



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Birth Of A Decade

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Five years after that conference a second gathering was organized. The Mid-Decade Conference was held in Copenhagen, Denmark. The numbers of UN participants were still strong but the most visable difference could be seen in the numbers of women who were joining the ranks of The Forum. The Nairobi conference marked what was known as The End Of The Decade Conference. Its mission was specifically to review and appraise the achievements of women throughout the decade. The number of women who traveled to Africa to participate in the largest Forum yet numbered over 13,000. The decade might have come to an end but the issues and interests that first began ten years ago are still burning in the hearts of thousands of women around the world. ♀

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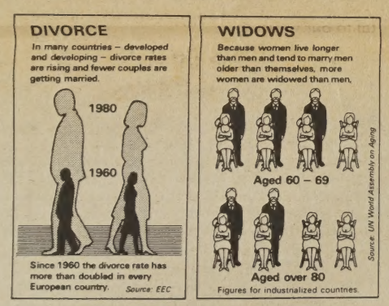
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December 1, 1985

Dear Sister Byllye Avery,

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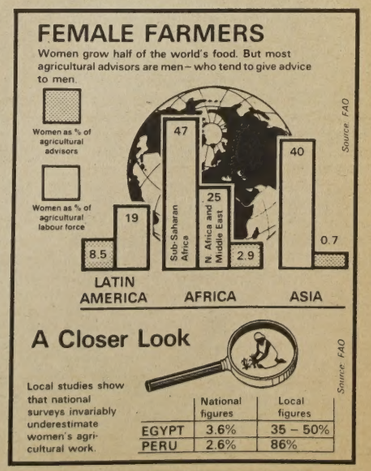

	National figures	Local figures
EGYPT	3.6%	35 – 50%
PERU	2.6%	86%

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TOXIC SHOCK SYNDROME: It hasn't gone away

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TSS cases are reported also, though less frequently, in females who use only menstrual pads; in females who are not menstruating; in users of contraceptive sponges and diaphragms; in people with infections related to insect stings, wounds, surgery; and in men and children. Tampons themselves have not been found to cause TSS, but scientists have determined that there is an association between TSS and tampon use. The exact nature of this association remains unclear.

The Food and Drug Administration has developed a self-contained learning unit about TSS and is pushing a national educational campaign about the disease. The unit is contained in a poster format and offers background information, visual reinforcement, lesson plans, tests and camera ready panels for photocopying. To receive your unit or for futher information contact Annette Funn at the Department of Health and Human Services, Food and Drug Administration, Rockville, Md. 20857. ♀

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Although the FDA—after many deaths—banned the device in 1974, Robins allowed ten years to elapse before launching a token national recall campaign in October, 1984. The evidence of the detrimental consequences of Dalkon Shield use continued to mount. Meanwhile, Robins has done nothing at all in the international arena where indeterminate numbers of women are still wearing the device; devices which were sold, often unsterilized, to developing countries because after implant little "monitoring" would be required. These women are being denied information necessary to save their lives. [We view this phenomenon as yet another example of the havoc and tragedy that result whenever the vulgar notions of racism, sexism, and imperialism interface.]

It appears that Robins will be granted a class-action status in which all remaining claims will be settled with one trial. A committee of 38 bankruptcy court-appointed attorneys was constituted to represent all women who have been injured by the Dalkon Shield as well as any infants damaged by the device. As a consequence of the efforts of isolated individuals, an infinitesimal fraction of the affected women have filed personal injury claims on behalf of themselves and their children against A.H. Robins. As of April, 1985 13,000 claims had been filed. That this number includes virtually no foreign claims does not astonish us—so far, no claims have been filed from Africa, India, Central or South America.

The Dalkon Shield is a dangerous IUD that has been recalled. If you have used a Dalkon Shield and suffered pelvic infections, miscarriage, infertility, had children with birth defects, or if it has not been removed, call, toll free, 1-800-DS Alert starting January 10, 1986. Personal injury claims must be filed by April 30, 1986. Action Alert for Women is women helping women!

Action Alert For Women is a Bay Area based group whose mission is to inform the national and international women's community of the dangers of the Dalkon Shield. Represented on our Steering Committee are several women who attended the U.N. sponsored International Decade for Women Conferences in Copenhagen, Denmark (1980) and Nairobi, Kenya (1985). Our concern for our sisters both here and abroad is fundamental to our work. ♀

The Effects of Aerobics

As more and more women are getting into exercise, aerobics is the one that most women choose. As you may or may not know, the aerobics industry is relatively young. Most aerobics classes are held in spas, health clubs, Y's, and community centers. Classes are led by an instructor who may or may not be *certified!* What does being certified mean? It means that the person attends a workshop or seminar that taught them the principles of Aerobic dance, muscle groups and what they do, and techniques in exercise safety and injury prevention. Certification programs range in length of one day to six months, depending on which certification organization you use. The contents of each program may differ. This is why there has been such an outcry for national certification.

National certification has been a major concern of the International Dance – Exercise Association (IDEA). IDEA is an organization that many aerobics instructors belong to. When plans for national certification first started, a certification committee was formed that worked with the American College of Sports Medicine (ACSM). That was almost two years ago. Recently, the ACSM has chosen to break from the IDEA's national certification effort. IDEA seems to feel that the process of developing national standards will proceed at a faster pace. How will national certification affect you? If you are an aerobics instructor you will have to meet national standards by taking the certification exam without enrolling in a training program or taking the exam through a training organization. For the consumer, this may affect the cost of a class or joining the health spas and clubs. There are many training organizations and national standards that will help to get rid of the ones that are not up to par. I personally feel that national certification standards are needed. This will give the public better protection against instructors who use unsafe practices.

It is very important that Black instructors stay in touch with new developments in the national plan. I would like to hear your opinion on national certification. If you are an instructor, state whether you are in IDEA or any other Dance – Exercise Association. ♀

Noell Sewell P.O. Box 7494 Phila., Pa. 19101

Continued from page 2

There is "women's work" in Africa just like there is everywhere else. Particular to African women is the task of carrying water. We followed Ester down the side of a steep mountain while she went about her daily task of filling a 3 gallon jug up to its brim, strapping it to her forehead and climbing back up without spilling a drop. Ester was incredible and I found myself angry at how incredible she *had* to be. It disturbed me that the women had to have such grueling difficult lives. It disturbed me that so many of the men who had been pushed out of work because of the quick industrialization many areas were undergoing just sat around and watched while the women broke their backs for their families. There were many questions my western mind kept proposing. Many of them got answered but even that did not take the bad taste out of my mouth.

We ended our day at Karuna with close dialogue with the women. They told us that they did not have to deal with rape. It was stated that that was primarily an urban problem. The question of incest took much explanation. There is no Kikuyu word for it. They could not even imagine such an atrocity. Depo-Provera was definitely a problem all over the countryside. The women referred to it as "The Shot".

Education and Health • In any country the best way of safeguarding the welfare of children is to invest in the education and health of their mothers. If this were to become an international policy statement children's lives would improve on all levels.

Ester and the other women of Karuna made a difference in my life that day. We connected, both silently and out loud. The problems we have in this country as Black women mirror the problems our sisters across the water have. We are never alone in our burdens but neither are we alone in our faith and hope for a new day comin' just around the bend. ♀

Birth Of A Decade

Discussions about having a United Nations Conference on women began in 1972. In light of the growing international women's movement, the UN declared 1975 International Women's year and called for a world conference to be held in Mexico City in June of that year. At that particular conference while the UN delegates were working out their political differences some 6,000 other women representing a variety of non-governmental organizations from around the world (all non-governmental) began having their own dialogues. These organizations ranged from small grass-roots groups to well-funded international giants. Most of them included something in their focus about social change. This was the beginning of what we now know as The Forum.

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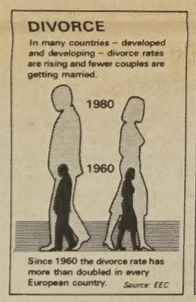
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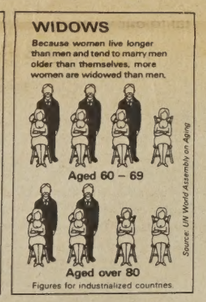
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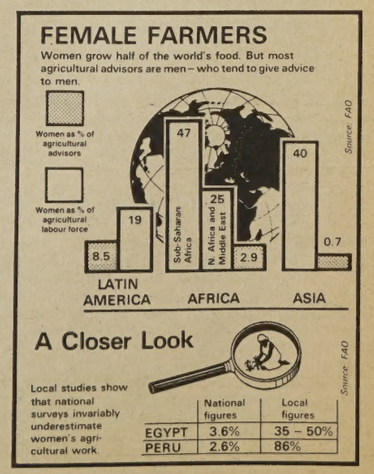

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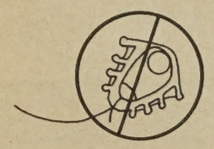

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Action Alert For Women is a Bay Area based group whose mission is to inform the national and international women's community of the dangers of the Dalkon Shield. Represented on our Steering Committee are several women who attended the U.N. sponsored International Decade for Women Conferences in Copenhagen, Denmark (1980) and Nairobi, Kenya (1985). Our concern for our sisters both here and abroad is fundamental to our work. ♀

The Effects of Aerobics

As more and more women are getting into exercise, aerobics is the one that most women choose. As you may or may not know, the aerobics industry is relatively young. Most aerobics classes are held in spas, health clubs, Y's, and community centers. Classes are led by an instructor who may or may not be *certified!* What does being certified mean? It means that the person attends a workshop or seminar that taught them the principles of Aerobic dance, muscle groups and what they do, and techniques in exercise safety and injury prevention. Certification programs range in length of one day to six months, depending on which certification organization you use. The contents of each program may differ. This is why there has been such an outcry for national certification.

National certification has been a major concern of the International Dance – Exercise Association (IDEA). IDEA is an organization that many aerobics instructors belong to. When plans for national certification first started, a certification committee was formed that worked with the American College of Sports Medicine (ACSM). That was almost two years ago. Recently, the ACSM has chosen to break from the IDEA's national certification effort. IDEA seems to feel that the process of developing national standards will proceed at a faster pace. How will national certification affect you? If you are an aerobics instructor you will have to meet national standards by taking the certification exam without enrolling in a training program or taking the exam through a training organization. For the consumer, this may affect the cost of a class or joining the health spas and clubs. There are many training organizations and national standards that will help to get rid of the ones that are not up to par. I personally feel that national certification standards are needed. This will give the public better protection against instructors who use unsafe practices.

It is very important that Black instructors stay in touch with new developments in the national plan. I would like to hear your opinion on national certification. If you are an instructor, state whether you are certified. Also state whether you are in IDEA or any other Dance – Exercise Association. ♀

Noell Sewell P.O. Box 7494 Phila., Pa. 19101

Continued from page 2

There is "women's work" in Africa just like there is everywhere else. Particular to African women is the task of carrying water. We followed Ester down the side of a steep mountain while she went about her daily task of filling a 3 gallon jug up to its brim, strapping it to her forehead and climbing back up without spilling a drop. Ester was incredible and I found myself angry at how incredible she *had* to be. It disturbed me that the women had to have such grueling difficult lives. It disturbed me that so many of the men who had been pushed out of work because of the quick industrialization many areas were undergoing just sat around and watched while the women broke their backs for their families. There were many questions my western mind kept proposing. Many of them got answered but even that did not take the bad taste out of my mouth.

We ended our day at Karuna with close dialogue with the women. They told us that they did not have to deal with rape. It was stated that that was primarily an urban problem. The question of incest took much explanation. There is no Kikuyu word for it. They could not even imagine such an atrocity. Depo-Provera was definitely a problem all over the countryside. The women referred to it as "The Shot".

Education and Health • In any country the best way of safeguarding the welfare of children is to invest in the education and health of their mothers. If this were to become an international policy statement children's lives would improve on all levels.

Ester and the other women of Karuna made a difference in my life that day. We connected, both silently and out loud. The problems we have in this country as Black women mirror the problems our sisters across the water have. We are never alone in our burdens but neither are we alone in our faith and hope for a new day comin' just around the bend. ♀

Issues Covered at the Conference Included:

Female Circumcision

"Amputation of the clitoris and sometimes even of the external genital organs goes hand in hand with brainwashing of girls, with a calculated merciless campaign to paralyze their capacity to think and to judge and to understand. Far down the ages a system has been built up which aims at destroying the ability of women to see the exploitation to which they are subjected, and to understand its causes. A system which portrays the situation of women as a destiny prescribed by the Creator who made them as they are, females and therefore a lesser species of the human race."

Genital mutilation is a means of controlling women and inhibiting their sexuality. It is a practice that began during the reign of the Pharoahs in Egypt as well as in Europe during the 19th century. It is still practiced in Sudan, Ethiopia, Somalia, Tanzania, Kenya, in some west African countries, and in many middle eastern countries such as Iran and Saudia Arabia. There are two main forms of female circumcision. Infibulation involves the removal of the clitoris, labia minora, and the interior two-thirds of the labia majora. This wound is then forced to form scar tissue leaving an opening only big enough to allow for the passage of urine and blood. Excision involves the removal of the clitoris only.

Since 1959 some laws have been enacted against genital mutilation. But in general all of them have failed on all levels of enforcement. Female circumcision has existed as a rite of passage for girls as they enter womanhood. It is said to represent her new ability to accept responsibility. And then there are the societal pressures placed on women. Most of the countries practicing genital mutilation believe it is a purification process. The implicit belief is that women's bodies are not acceptable as they are. Without the operation women are told from generation to generation that men would not be attracted to them nor would want to marry them.

Genital mutilation has been known to cause immediate and long term health hazards; shock, *hemorrhaging, damage to vital organs, child and* maternal deaths and other negative health consequences. A well organized and quickly growing campaign against this ancient practice is now being waged. Many barriers exist in the fight to eradicate genital mutilation. The hard work and persistence of women around the world are at the helm of the struggle. ♀

Photo : Mike Abrahams/NETWORK

Black Women's Reproductive Rights

There are three key and interconnected aspects of reproductive rights – access to abortion, infant mortality and forced sterilization. It is through these three issues that working women, Black women and women of color experience the brutality of the U.S. domestic population control policies. The key issues of reproductive control in any society differ depending on the social, political and economic conditions in which we as women find ourselves. What is common, however, is that a woman's capacity to make decisions about when, whether and under what conditions to have children is central to her full participation in society. As Black women and women of color from the U.S., we have learned in just the first few days of the UN End-Decade Conference on Women that we share many of the same conditions as our sisters around the world – high infant mortality rates, forced sterilization, poor quality or non-existent prenatal care, inadequate sex education, high under and unemployment and the attendant disproportionate share of poverty for our families and children.

There are many factors limiting Black women's rights in the U.S. For the most part, however, the U.S. government's population control policies, backed by enormous financial reserves, are the main barrier to full reproductive freedom both internal to the U.S. and abroad. The U.S. has the most advanced technology in the world, technology which could bring reproductive freedom and an enlightened attitude towards women's sexuality. Instead, the U.S. can boast of a thriving pornography industry, massive ad campaigns depicting women as nothing more than sex objects, and the highest rates of rape, incest and domestic violence in the developed world. Simultaneously, the U.S. cultivates a rising fundamentalist religious trend which, under a "pro-life" banner, actively opposes funding of a wide range of birth control methods, denounces abortion and blocks any form of sex education. This conservative sector is determined to return women to the confines of the kitchen and the home, and exclude women from full political and economic integration into society.

Because we lack fail-safe birth control methods and adequate sex education, access to safe, legal and affordable abortions is critical to the well-being of women of color in the U.S. Lest we forget, during the early 1960's, in the years prior to the legalization of abortion, 94% of the deaths in New York related to illegal abortion procedures were of Black and Puerto Rican women. In Georgia during the years 1965-67, the Black maternal death rate due to abortion was 14 times that of white women. Before legal abortion, skin color and class differences literally tipped the scale towards life or death for women seeking abortion to terminate an unintended or unwanted pregnancy.

The infant mortality rate is recognized internationally as an indicator of the quality of life of any population or sector of the population. In the U.S. the infant mortality rate overall is 11.5 per 1,000, the highest in the Western world. White rates are 10 per 1,000 while Black rates are 19.6 per 1,000 – twice as high as the average and often five times as high as the white rate in the same geographic area. For example, in Oakland in 1976, the Black infant mortality rate was 21 per 1,000 compared to 3-5 per 1,000 in neighboring affluent white Piedmont. Today, in Washington, D.C., the Black infant mortality rate remains a disgraceful 21 per 1,000. So while we live in a country where advanced technology can save premature babies through extraordinary intervention, Black and brown babies die in their first year of life due to inadequate provision of basic health care services to our women and children – in short from poverty and racism. One in every 10 Black women in the U.S. receives no prenatal care or only late third trimester care. Among Black teen-age mothers under 15, 1 in 10 receive no or late prenatal care. The U.S. has the highest rates of teen-age pregnancy, abortion and infant mortality of the developed nations although there is no difference in the rate of sexual activity.

For Black women in the U.S., a vital component of achieving control over our reproductive lives is a health care system which allows us to have healthy babies, healthy children and healthy families. Yet we are saddled with a government policy which keeps reducing social welfare and service programs to the point where preventative health care is unattainable. Aid to Families with Dependent Children (AFDC) and the Women, Infants and Children (WIC) nutrition programs have been cut to the bone. There is nothing puzzling about the callousness of the current administration which allows our babies to die. This is nothing more than a subtle form of genocide.

As Black women in the U.S., reproductive rights issues are central to our political work. Our communities, our families, our development as active, participating women suffer greatly from the distorted priorities of our government. Death, not life, is on their agenda. The billions of dollars siphoned to maintain war could subsidize dramatically the needed health care, family planning, and social services that would insure a decent quality of life in our communities. Our work is cut out for us. With all of our energy, together in unity, we can realize a better future for ourselves, our daughters and our sons. ♀

This presentation was given by **Melanie Tervalon, M.D.,** as part of a workshop organized by the National Black Women's Health Project for the 1985 End of the Decade Conference.

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The Wages for Housework Campaign has been organized since 1972 and its goal is to work for recognition and compensation for houseworkers worldwide. At the 1980 International conference in Copenhagen they raised the issue of housework being economically uncompensated labor and soon after launched a petition campaign to get all women's work included in the Gross National Product.

On July 18 at the UN World Government Conference in Nairobi, the International Wages For Housework Campaign won a major victory. Governments in Committee agreed to include all women's work, paid and unpaid, in the Gross National Product of every country. The GNP is supposed to be the total value of goods and services produced, but up to now it has only included goods and services exchanged for money. This victory is the result of massive pressure from the women gathered in Nairobi, and from women who raised this issue in every country of the world. ♀

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Health has to do with every aspect of our lives. It has to do with the kind of foods we eat, the type of roof over our heads, the kinds of daily tasks we know as work. Health cannot be separated from the political, economic and cultural systems of our society. We must begin to look at health as the window from which our lives as women are viewed.

An overview of what its like to be a healthy or unhealthy woman in this world is key in arriving at the complete picture of women across the globe.

If we were to look at health systems in most countries money continues to pour out for high technology medicine, which is not only terribly expensive but such care also requires modern western-styled institutions. This type of care usually only benefits an urban elite population. Many long term investments in health such as eliminating pollution, providing clean water as well as proper access to nutritious food and vaccinations are usually overlooked.

The focus on "medical care" as opposed to "health care" is intricately connected to the incredible growth of the pharmaceutical industry, one of the most profitable industries in the world. Much of the research the pharmaceutical companies do on drugs has undoubtably grown out of very specific health needs but it is also true that currently 50 times more money is spent on researching cancer than on all other tropical diseases put together. The majority of these companies influence health care by investing in drugs which they think will sell.

The medical profession, which is a major dispenser of pharmaceutical products, plays a pivotal role in how world health is viewed and defined. The profession is an old prestigeous one. And usually it is men who emerge the dominant figures in it. But anyone who knows anything about health knows that women have always been healers. They were the unlicensed doctors of western history. They were the earliest abortionists, nurses and counselors. They were the ones with their pharmacies growing out in the back yard, exchanging and passing on the secrets of the herbs to other women who were responsible for caring for other people.

Health as a development concept must be seen through wider eyes than Western ones. In industrialized countries the women's health movement has used the term self-help to denote the taking back of power over their own bodies. But in many developing countries the situation is completely reversed. The vast majority of women have no access to any kind of health care system, and where it does exist it is usually expensive or severely inadequate.

Maternal and child health services have been the traditonal women's health topics. Malnutrition, fatigue stress and overwork have basically been overlooked as viable areas of concern. The backbreaking tasks of water-fetching and sub-sistence farming done by rural women in developing countries can no longer be overlooked or ignored.

As nations of women begin talking and networking more and more it is clear the old definitions of what health is and what women will no longer stand for will be a crucial brick in the next decade of our development. ♀

Domestic Work • If women of the world were paid for domestic work and child-care their wages would account for up to half of most national incomes.

In South Africa

Loide Shinavene of SWAPO (South African People's Organization) told of the atrocities committed in Namibia by South African troops:

"In Namibia the situation is very very bad when it comes to racism ... There are squads ... for whom killing is the order of the day. In the northern part of Namibia, South African policy is to make allegations that civilians are SWAPO freedom fighters and to call them terrorists. The South African soldier can just go against a peasant and he needs no proof. Consequently, people are terrorized and their homes are burned down. These people do not have the right to state their case in court, where their cases are thrown out. Civilians are daily beaten up if they are queried about information that they often do not know. South African soldiers put on a SWAPO uniform and ask people for food at gunpoint. Next day they come back in their South African uniform and detain the people, saying that you gave food to SWAPO terrorists. One elderly man was burned alive. Soldiers wanted to rape his wife when she said she was married.

This army claims they are protecting the people in the northern part ... but they are really killing people, and we know who is supporting South Africa. There are two concentration camps in the north and this is kept very quiet and secret ..."

Loide continued with a listing of many injuries and atrocities perpetrated against the Namibian people during recent attacks by the South African army.

"The people who suffer most are women and children," she said, "as you can imagine if this situation happens every day. But we in SWAPO are ready to fight to the bitter end, until the system of apartheid is defeated in Namibia and until the total independence of our country is won!"

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New Caledonia became a French colony in 1853. In the decades that followed an apartheid system was introduced under which the Kanak people were dispossessed of their tribal lands and herded into small infertile reservations. Tens of thousands died from starvation and disease. Thousands more were massacred following attempted rebellions against the French. Today the Kanak population numbers a little over 60,000, while the number of European settlers (predominately French) in New Caledonia numbers around 54,000.

New Caledonia is a country rich in minerals and highly productive farmland. For over a century this wealth has been plundered by imperialism, while the Kanak people have been kept in a state of abject poverty. Today the Kanak people are fighting to regain their homeland. Their struggle is a symbol of a new awakening of the indigenous people of the Pacific. Since 1984 over 20 Kanaks have been killed, scores have been tortured, and over 100 political prisoners are being held in jail. Presently, the French government is conducting Nuclear testing in the waters surrounding New Caledonia. Because of this testing high incidences of cancers, diseases and birth defects are now becoming commonplace among the Kanak people who create their livlihood from the ocean.

The Kanak's struggle for independence and freedom is not a new one. They desperately need help on an international scale. If you would like to join this struggle you may contact Susan Ounei at 135-3r Cite Pierre, Lenquette Nouveou, New Caledonia. ♀

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OUR AFRICAN JOURNALS: A Peek Inside

My African journey begins in Dakar, Senegal. I leave the plane to set foot upon the pale sandy soil of a coastal city. My first glimpse of my homeland, much anticipated, with promises to kiss the ground is actually much more restrained and tentative. Reality rushes in before my knees can touch the ground. Africa, foreign land or homeland?

Barely off the plane and with just enough time to drop off our bags at the hotel, the twenty-four Black women I am travelling with find ourselves leaping across a two-foot chasm of seawater to board a creaky old boat overloaded with people heading for Goree Island.

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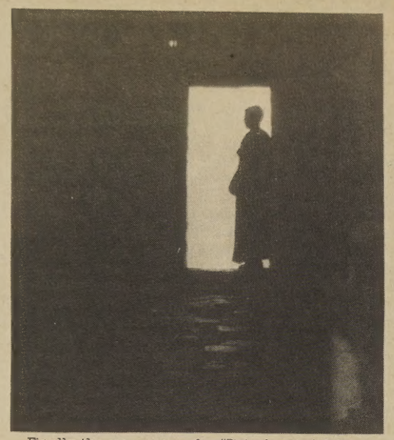

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There are many differing opinions about what happened in Nairobi. Many found the atmosphere in the city itself oppressive while others ignored the regimented police state Nairobi appeared to be in and gravitated towards the incredible warmth of its people. Two things cannot be disputed, the invaluable amount of networking that went on and that it was clearly the largest gathering of Black women from Europe, Canada, The West Indies and every other corner of the globe that had ever attended any of the previous conferences. If you were there you know exactly the magic I'm talking about. If you weren't just close your eyes and imagine it. One thousand of us stepping off different planes from different places. Some of us in high heels, some in flip-flops, with our hair buoyant with curls or thick with locks, with eyes and faces the same shape and color as the women who welcomed us off the plane.

Continued on page 8

In Answer To Your Question 'Have You Ever Considered Suicide?'

Suicide?
Girl, Is you crazy
I'm scared I'm not gonna live long enough
as it is

I'm scared of
high places
fast moving trucks
rare diseases
muggers
drugs
electricity
and folks who work roots

now what would I look like
jumping offa something
I got everything to do and
I ain't got time for that

Let me tell you something
If you ever hear me talking about
killing my frail self
Come and get me
Sit with me until that spell passes
'Cause it will

And if they ever find me
Laying up somewhere
Don't let them tell you it was suicide
'Cause it wasn't

I'm scared of
High places
Fast-Moving Trucks
Rare diseases
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Electricity
Folks who work roots
And home-canned string beans

Not with all that to worry about
What would I look like
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Continued from page 6

In June of 1983 I attended the First National Black Women's Health Conference at Spelman College in Atlanta. At that conference I learned about the UN sponsored International Women's Conference to be held in Nairobi, Kenya in July of 1985. I was among many women at the Spelman gathering that experienced an immediate urgent desire to make preparations for attending that historic "Forum '85" event in Nairobi.

The fact that a conference of such magnitude and importance was being held on the "Mother Continent" and in Eastern Africa, the cradle of humankind, excited me even more. Many of us, as African-American women would return "home" for the first time in our lives. The anticipation of having the opportunity to meet and engage in dialogue with women who are activists and leaders of varying types of social and national liberation struggles around the world fueled and intensified my efforts in organizing to get to Nairobi. Many participants, including myself, made grave personal and financial sacrifices to get there. That attests to the extremely heightened political development and overall awareness of women worldwide.

The NGO Forum '85, Nairobi experience was immense, multidimensional, multifaceted, and deeply heartfelt. The intensity of my mind expansion, intellectual and spiritual connectiveness with my international sisters astounds me even now, four months after Nairobi. Forum '85 provided an international arena for women to exchange and share their politics, cultures and histories. Our National Black Women's Health Project conferees constantly sought out opportunities for those exchanges to occur. One such momentous occasion was when our "Project" met with about 50 Kenyan women. It resulted in their desire to develop a Kenyan National Black Women's Health Project.

We shared our life histories, cultural experiences, and enjoyed singing and dancing together. It was wonderful. Sisters from rural areas, health practioneers, factory workers, mothers and daughters, etc. all partook in our exhilarating historical event. We were continuously reminded at our "special event" and by our African sisters everywhere throughout the conference, that "You have come home" and that "you have not been forgotten." ♀

Zakiya N.T. Somburu

When we arrived in Dakar, Senegal I had to go inside myself and meditate to calm my spirit down. We had reached the continent and I wanted more than anything to connect with the earth, to have my feet touch ground.

Our first journey took us to Goree Island, The Slave Island. When we arrived at the dock I realized I was under false illusions. This trip wasn't going to be like any other tourist trip and that glossy brochure I had seen didn't capture the intensity growing inside of me. I was expecting a small version of the Pacific Princess, a ferry of sorts and was surprised when presented with a small tug boat. There was no special boat for tourists, only the one taken by the Africans from the island to the mainland. It had no stairs, no ramp, and the boat and dock met on different levels which meant we had to jump from one point to the other. Most of us sat quietly on the boat, some spoke of their fear of the water (we were all aware that the ocean has no bottom), others bravely tried to engage in French conversation with the Africans.

Female Industrialization • The majority of the women in business don't carry briefcases or smoke big cigars. They don't dress in three piece suits or carry business cards. But women traders and vendors create up to a third of the wealth in many third world cities.

I was met on Goree by the eyes of an African child looking up, addressing me as madam, asking for money. Carlos (our tour guide) had already advised us not to respond. What I needed him to advise me on was how not to feel guilty because to this child I represented a rich American.

MAISON DES ESCLAVES, read the inscription over the entrance meaning house of slaves. Again I was not prepared for the emotions that swept over me. No book had ever captured this intensity, no book had ever brought life to the slave trade for me as did this experience. I could feel the presence of the sixty million who died on the island, could hear those who cried out in pain as I entered the room of torture. Standing there, I focused on the walls, they began closing in. I heard sounds ... of slave names, chains, whips, moans, moans, moans. I walked backwards trying to escape the energy, the shadows followed. Held hands over ears to shut off the many voices. I wanted to leave the island, run away, swim to the main-land, but like my ancestors I am not a strong swimmer, I too would not survive. Yet, the water looked so calm, so gentle in comparison that I understood the reason some chose to jump.

Water splashed against my skin and brought me back to reality; I was on the boat back to the mainland. The water was from a group of boys in play deciding to ride the boat halfway to Dakar only to jump off and swim back to Goree. I remembered the many slaves who drowned.

As the boat tugged closer to Dakar, Goree became a blurred smoked covered vision. The experience has stayed with me and will affect the rest of my stay in Africa as well as the rest of my life. The little boy who called me madam followed me to my dreams. The woman who taught me how to bargain, not understanding my guilt, created a lesson as I continue to grasp the different meanings of respect and survival. Last of all, I no longer believe in ferries. ♀

Marcella Quaziena

OUR AFRICAN JOURNALS: A Peek Inside

My African journey begins in Dakar, Senegal. I leave the plane to set foot upon the pale sandy soil of a coastal city. My first glimpse of my homeland, much anticipated, with promises to kiss the ground is actually much more restrained and tentative. Reality rushes in before my knees can touch the ground. Africa, foreign land or homeland?

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We begin to move down a narrow passageway that ends in a flood of light. I move forward to hear the guide's explanation of a large rectangular door cut into the rock and opening on to a twenty-foot drop to the sea and jagged rocks below. The guided tour ends here for me as our guide explains that at this portal, the Africans, my ancestors, most brought here from the interior of the continent, stood in this very place and viewed the sea for the first time and their homeland for the last. For it is here that they boarded the ships.

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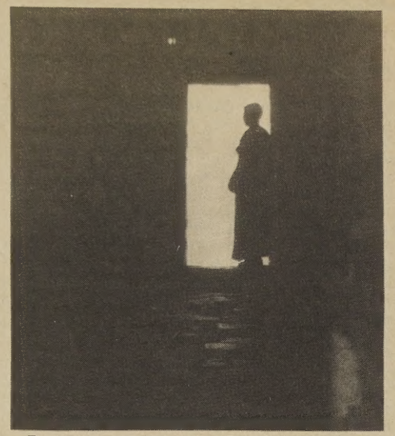

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Let me tell you something
If you ever hear me talking about
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Come and get me
Sit with me until that spell passes
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And if they ever find me
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In June of 1983 I attended the First National Black Women's Health Conference at Spelman College in Atlanta. At that conference I learned about the UN sponsored International Women's Conference to be held in Nairobi, Kenya in July of 1985. I was among many women at the Spelman gathering that experienced an immediate urgent desire to make preparations for attending that historic "Forum '85" event in Nairobi.

The fact that a conference of such magnitude and importance was being held on the "Mother Continent" and in Eastern Africa, the cradle of humankind, excited me even more. Many of us, as African-American women would return "home" for the first time in our lives. The anticipation of having the opportunity to meet and engage in dialogue with women who are activists and leaders of varying types of social and national liberation struggles around the world fueled and intensified my efforts in organizing to get to Nairobi. Many participants, including myself, made grave personal and financial sacrifices to get there. That attests to the extremely heightened political development and overall awareness of women worldwide.

The NGO Forum '85, Nairobi experience was immense, multidimensional, multifaceted, and deeply heartfelt. The intensity of my mind expansion, intellectual and spiritual connectiveness with my international sisters astounds me even now, four months after Nairobi. Forum '85 provided an international arena for women to exchange and share their politics, cultures and histories. Our National Black Women's Health Project conferees constantly sought out opportunities for those exchanges to occur. One such momentous occasion was when our "Project" met with about 50 Kenyan women. It resulted in their desire to develop a Kenyan National Black Women's Health Project.

We shared our life histories, cultural experiences, and enjoyed singing and dancing together. It was wonderful. Sisters from rural areas, health practioneers, factory workers, mothers and daughters, etc. all partook in our exhilarating historical event. We were continuously reminded at our "special event" and by our African sisters everywhere throughout the conference, that "You have come home" and that "you have not been forgotten." ♀

Zakiya N.T. Somburu

When we arrived in Dakar, Senegal I had to go inside myself and meditate to calm my spirit down. We had reached the continent and I wanted more than anything to connect with the earth, to have my feet touch ground.

Our first journey took us to Goree Island, The Slave Island. When we arrived at the dock I realized I was under false illusions. This trip wasn't going to be like any other tourist trip and that glossy brochure I had seen didn't capture the intensity growing inside of me. I was expecting a small version of the Pacific Princess, a ferry of sorts and was surprised when presented with a small tug boat. There was no special boat for tourists, only the one taken by the Africans from the island to the mainland. It had no stairs, no ramp, and the boat and dock met on different levels which meant we had to jump from one point to the other. Most of us sat quietly on the boat, some spoke of their fear of the water (we were all aware that the ocean has no bottom), others bravely tried to engage in French conversation with the Africans.

Female Industrialization • The majority of the women in business don't carry briefcases or smoke big cigars. They don't dress in three piece suits or carry business cards. But women traders and vendors create up to a third of the wealth in many third world cities.

I was met on Goree by the eyes of an African child looking up, addressing me as madam, asking for money. Carlos (our tour guide) had already advised us not to respond. What I needed him to advise me on was how not to feel guilty because to this child I represented a rich American.

MAISON DES ESCLAVES, read the inscription over the entrance meaning house of slaves. Again I was not prepared for the emotions that swept over me. No book had ever captured this intensity, no book had ever brought life to the slave trade for me as did this experience. I could feel the presence of the sixty million who died on the island, could hear those who cried out in pain as I entered the room of torture. Standing there, I focused on the walls, they began closing in. I heard sounds ... of slave names, chains, whips, moans, moans, moans. I walked backwards trying to escape the energy, the shadows followed. Held hands over ears to shut off the many voices. I wanted to leave the island, run away, swim to the main-land, but like my ancestors I am not a strong swimmer, I too would not survive. Yet, the water looked so calm, so gentle in comparison that I understood the reason some chose to jump.

Water splashed against my skin and brought me back to reality; I was on the boat back to the mainland. The water was from a group of boys in play deciding to ride the boat halfway to Dakar only to jump off and swim back to Goree. I remembered the many slaves who drowned.

As the boat tugged closer to Dakar, Goree became a blurred smoked covered vision. The experience has stayed with me and will affect the rest of my stay in Africa as well as the rest of my life. The little boy who called me madam followed me to my dreams. The woman who taught me how to bargain, not understanding my guilt, created a lesson as I continue to grasp the different meanings of respect and survival. Last of all, I no longer believe in ferries. ♀

Marcella Quaziena

vital signs

NEWS FROM THE NATIONAL BLACK WOMEN'S HEALTH PROJECT

VOLUME 3 NO. 1 January/1986

Vital Signs

A publication of the National Black Women's Health Project

Volume XII, Issue 2

Black Women: Maturing Healthy & Wise

Speaking Out on Health: Reflections of Midlife and Older Members of the NBWHP

1997

A newsmagazine communicating health issues affecting women of African descent, their families, and their communities.

SELF-HELP GROUP UPDATES •

SELF-HELP (help) n.
Care or betterment of oneself by one's own efforts, as through study.

BAY AREA BWHP – Recent activities culminated in a highly-successful, well-attended community forum in November, with Byllye Avery, Executive Director of the NBWHP, the featured speaker. As the number of inquiries continues, attention is being directed to self-help development and organizing meetings in Bay Area communities. The Bay Area chapter has received funding from Vanguard and the Women's Foundation for development of programming and financial management. April 1986 will be a busy month as plans call for a conference on Black Women's Health Issues and chapter induction ceremonies.

ALBANY, GEORGIA – Self-help organizing activities got off to a good beginning with "A Celebration and Tribute to Midwives and Caretakers" in October. Membership drive activities were highly successful as Albany brought over 15 members into the NBWHP fold.

PORTLAND, OREGON – An air of excitement and renewed commitment is evident in the Pacific NW as a result of the awarding of a mini-grant to the Portland chapter by McKenzie River Gathering to further community outreach/information, task force participation and self-help development efforts. Chapter members are turning their interests to preparations for their chartering ceremonies in Janaury, 1986.

NORTH CAROLINA – The model self-help development efforts that were begun in North Carolina are already bearing fruit. The eastern part of the state has been engaged in several highly-visible, successful health activities that have gamered significant local support, and added new members to the chapter's roster. Primary activities have been the Saturday health walks sponsored by the Greenville area chapter. Additionally, 21 women were inducted into NBWHP in ceremonies in Greenville in December. Radio talk show hostess, Barbara Fenner, has utilized her Sunday morning program to keep the community informed of chapter activities, as well as to promote the discussion of health topics.

North Carolina will convene a conference on Black Women's Health Issues in January in Charlotte. The conference is sponsored by the Mecklenburg County Women's Commission, Blueprint for the 80's committee.

NEW YORK, NEW YORK – New York development efforts were recently spearheaded by a forum to establish the working plan for self-help activities in New York communities, the creation of a planning committee to determine the direction of development and outreach, and the beginning of the process to establish active chapters of the NBWHP in New York.

PATERSON, NEW JERSEY – Following a successful membership drive, the Paterson chapter presented a well-attended community forum. The local chapter is actively pursuing self-sufficiency as evidenced by their location of a supplier for jogging suits; any chapters interested in a reasonable price for quantity orders of the "Project" jogging suit, should contact the New Paterson, New Jersey chapter c/o Martha Bolds.

Look for self-help chapters to emerge in Trenton and Newark shortly.

GRAND RAPIDS, MICHIGAN – Following a site visit to the chapter by Byllye Avery, Executive Director, in early November, the Grand Rapids chapter has begun planning work for a conference on Black Women's Health Issues to convene in May, 1986.

NEW ORLEANS, LOUISIANA – The New Orleans chapter has been highly visible in the local community with forums, dialogues with teenagers, and issues sessions on the health of the Black family. Official induction ceremonies took place at Dookie Chase Restaurant in October, preceeded by a moving Service of Consecration, with the chapter 'sitting in' at a local church.

FLORIDA – The awarding of a mini grant from the Bert and Mary Meyers Foundation will allow self-help development efforts to begin in earnest, in order to respond to the growing list of inquiries. Targeted communities for initial self-help development include Orlando/Apopka/Monteocha-Gordon/Alachua, Tallahassee, Deland/Lake Helen/Daytona Beach, and Jacksonville.

PHILADELPHIA, PENNSYLVANIA – The activity cycle has been particularly high in Philly with the seating of new board members, the final decision on a project Executive Director, and a management workshop conducted during a site visit by national staff. Kudos are in order for the dedicated, volunteer service "above and beyond the call of duty" by Pamela Freeman.

OKLAHOMA – Recent correspondence indicates our Midwest 'sisters' are revamping the local organizational efforts, and revitalizing themselves as they begin, anew, the task of working on issues of Black women's health. Plans are being formulated for a site visit by national staff to conduct organizing and empowerment workshops as the first step in identifying the important issues for local action.

JOIN NBWHP

The NBWHP is alive and well through the donations and generosity of its members. Please join us today!

Yes, I share your vision. I would not miss this opportunity to join this movement for health and wellness:

I wish to join as a:

Self-Help Member
☐$25 ☐$15 (low income)

Sisters
☐$25 ☐$15 (low income)

Brothers
☐$25 and up
☐$50 ☐$100

Enablers
☐$25 and up
☐$500 - up

I do not choose to join at this time but I want to contribute $_____ to the organization.

Name _____

Address _____

City _____ County _____

State _____ Zip Code _____

Telephone ( )_____(Home)

( )_____(Office)

Employer _____
(Information for potential Matching Grants)

Self-Help Group Chapter _____

City _____ State _____

Your contribution to the NBWHP is tax deductible.

Continued from page 5

U.S.-U.S.S.R. Dialog Held in Peace Tent

A high point at Forum '85 was the U.S.–U.S.S.R. Dialog held in the airy blue-and-white striped peace tent that took center stage in the ongoing activities. U.S. participants were Bella Abzug of Women USA, Cora Weiss of the New York City Riverside Church Disarmament Campaign, Blue Ridge Mountain peace activist Ann Beall, and Connie Van Praet of the Washington, D.C.-based Institute for Security and Cooperation in Space. USSR participants were Zoya Zarubina, a professor at Moscow University and head of the Soviet Women's delegation to the Forum, Natalia Berezhnaya, Secretary of the Soviet Women's Committee. The discussants agreed on the urgent need to increase contacts between the people of the U.S. and the Soviet Union and to hold simultaneous and other coordinated peace activities so as to strengthen the international women's peace movement and break the Cold War deadlock. It was clear to the presentors as well as to the hundreds of women who sat in the audience from all over the world, that the unified voices of women would accept nothing less than global peace. ♀

The **National Black Women's Health Project** Newsletter is published four times a year. The editorial policy of this newsletter is to accept and encourage articles and correspondence from individuals whose work focuses specifically on the health care of Black Women.

Continued from page 7

This issue is divided into two parts. One section is specifically a peek into some of the one thousand workshops that took place at the Nairobi Forum. The second part has to do with how our hearts were feeling about just being in Africa. For the majority of us it was our first trip to those special shores, for others it was a time of joyous return. The connection that we made with Africa and Africans is what we remember most. It is at the heart of what we have chosen to share with you. ♀

Nikky Finney

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Vital Signs

A publication of the National Black Women's Health Project

Volume XII, Issue 2

Black Women: Maturing Healthy & Wise

Speaking Out on Health: Reflections of Midlife and Older Members of the NBWHP

1997

A newsmagazine communicating health issues affecting women of African descent, their families, and their communities.

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VITAL SIGNS

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VITAL FEEDBACK

Yes, we are all aging. The pioneers of the Black women's health movement are advancing into middle age or beyond. In fact, the postwar baby boom generation is moving into mid life, which means that this will be an age group to reckon with in every sense. The charge for Black women to take control of our own lives and of our bodies has developed thousands of Black women cadre for the Black women's health movement. The secret to a successful revolution is to have no fear. This Vital Signs' theme — ***Black Women: Maturing Healthy and Wise*** moves us in that direction, for it helps us to break down that formidable barrier in our minds — the fear of growing old. It helps us to see that mid life and old age are stages of life, as important as any other.

Older women are survivors, living an average of eight years longer than men, enjoying longer lifespans than we might as young women have expected to or planned for. Although there is a discrepancy between races, Black women born in 1994 can expect to live 73 years, compared with 64 years for Black men born in the same year. We can use our added years in ways that please us — learning new skills, traveling, and living out long-delayed dreams. Yet, as survivors, women are also likely to face more of the challenges of aging: chronic health conditions, inadequate income; Care giving responsibilities; lack of care when we need it.

Many women live from paycheck to paycheck, unable to save for retirement. Women of color are even less likely to have savings or other assets in retirement. Seventy-one percent of white women but just 33 percent of Latinas and 25 percent of African American women age 65 and older have income from assets. Single women, too, are less likely to have assets and savings. The two poorest groups in the U.S. today are women raising children alone and women over sixty-five living alone.

But let us not despair for at mid life, we can begin to make changes in order to avoid the isolation, poverty, and ill health that mar the later years of so many older women. Older women can change the circumstances of aging for all women, and men as well. Aging is a women's issue, and women's aging is a national issue. Throughout time women have been at the center of society. Women bind together families and communities: they rear youngsters, care for relatives, and staff positions in local governments and business. Many are volunteers in schools and in political, social service, and religious organizations. Much of their effort is unpaid, and often its economic and social value receives little recognition.

To develop aging policy for the 21st century, we must recognize that the aging of America intersects the changing roles of women realized over the past two decades — changes that affect workforce participation, family structure, societal expectations about formal care giving, and expectations about how women will behave in old age. We must identify, understand, and respond to the evolving issues confronting older women. Four areas are key: income security, health, care giving, and housing.

Black Women: Maturing Healthy and Wise denotes Black women arming themselves with knowledge and power as they age!! Knowledge building and policy analysis must undergird the educational activities of all Black women so that we mature healthy and wise, *indeed.*

In Wellness,

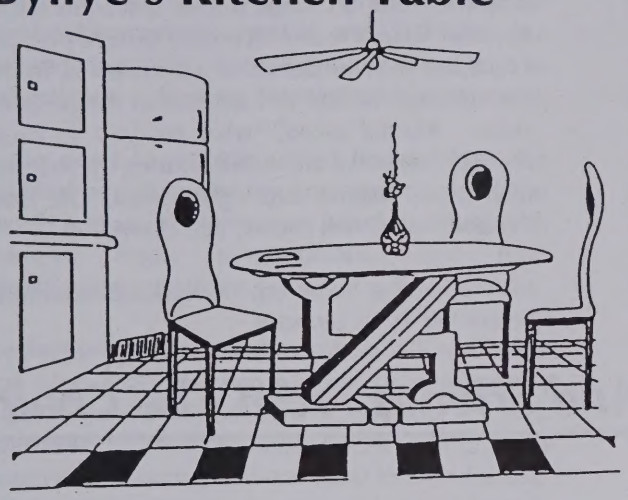
Tylene D. Harrell

Resources:

Body and Soul
By Linda Villarosa. In conjunction with The National Black Women's Health Project.

Ourselves, Growing Older
By Paula Brown Doress and Diana Laskin Siegal and the Mid-life and Older Women Book Project. In conjunction with The Boston Women's Health Collective, authors of The New Our Bodies, Ourselves.

Byllye's Kitchen Table



....Of Tender Years and Good Health

Byllye Y. Avery

Mary Louise Tarby, the beautiful woman pictured on the cover of Vital Signs, *lived for over 100 years.* I had the pleasure of meeting her in her 92nd year. Mamie was a petite woman who cared deeply about her appearance, stated that she thought it was important that she look good during her "tender" years. I rarely saw her without her lipstick, earrings and stockings on, and she wouldn't hesitate to ask "how do I look?"

One fall I picked her up in Boston and took her to visit her granddaughter, who lived in New Hampshire. When I offered to take her on this trip, I did not realize the responsibility involved in taking an elderly person on such a trip and immediately showed my distress by taking the wrong highway. I became so upset with myself, I stopped paying attention to Mamie, who was thrilled that we were lost. As she recognized the New Hampshire town, right outside of Boston, she was full of delight and excitement. "I thought I'd never see this part of the country again," she exclaimed.

As I shut off my anxiety, I started listening to the her wonderful stories about how the world had changed. I can still hear her as she gazed out of the window, casually saying, "a lot has changed in the past 100 years."

As we drove along the beautiful New Hampshire highway, she told me stories about her family. Her grandfather was born and raised in Vermont, as a free man. Her grandmother was the first Black person he had ever seen. The night that Lincoln was shot her grandfather and his brother were driving a buckboard from Washington, D.C. to Baltimore, MD. When we finally got on Highway 89 leading us to Hanover, NH, we saw a sign directing us to Concord, NH. Mamie started to laugh and tell me about the time her mother took a bus to Concord, MA trying to get to Concord, NH. Exasperated, she called to say that she gotten off at the wrong city at which point she took a *taxi to Concord, NH some 100 miles away!*

I listened carefully, as I realized what a blessed opportunity I had been given to sit and listen to wisdom and wit shared so freely. Her memory was sharp; she loved life and loved to talk about it. She never married, had no children of her own, and was godmother to two families, who happen to be African Americans, who have made significant

contributions to American society. An avid picture collector, she kept meticulous scrapbooks on the achievement of her "children."

Being with a person who is elderly made me think about life and health. How do we maintain our lives so we can live life to the fullest. In addition to being a careful and attentive person, she got her regular yearly checkups, she outlived her physician, and as she aged, she avoided drafts and going outside in the winter. I will always remember our late arrival that November day, a day so full of her memories of how the world had changed in 100 years. The season echoed its change with its first snow fall, big beautiful flakes created an instant picture post card. I squealed with the delight of a small child, for I am a southerner who is still amazed at the process of snow. Mamie asked, "what are you so excited about?" I said, "we are outside during the first snow of the year." Mamie laughingly replied, "Oh, I guess I've seen many first snows, yes, about 100."

Mamie lived at home until she passed two months before her 101st birthday.

A Message To Members And Friends From The Chair

Dear Members,

1996 was quite a year! Our re-organization process helped us to evaluate our past work, examine those activities done well, and evaluate critically those activities that need to be improved or discontinued. While we remain committed to our community base and self-help organizing, we are moving forward on our agenda to continue our programming and to provide more efficient membership services.

Julia Scott, our President, has been busy for the last six months preparing the office and staff for the next stage of the National Black Women's Health Project's (NBWHP) growth. Over the next few months, new staff members will be added to our national roster. Self help and walking for wellness groups continue to grow daily and four new cities have expressed their interest in becoming chapters. Several chapters have held self-help group leadership training sessions, thereby, enhancing their ranks and developing groups within local agencies. Two chapters have held citywide walks that have generated funds and friends. We are so proud of your work during this period.

Our newest endeavor, self-help group development for substance abuse prevention at seven Historically Black Colleges and Universities (HBCUs) which has been funded by the Robert Wood Johnson Foundation, is progressing very well. This collaboration between NBWHP, Center for Substance Abuse Prevention (CSAP), Center for Disease Control and Prevention (CDC), Office of Minority Health, Health Resources and Services Administration, Bureau of Primary Health Care, Office of Research on Women's Health and National Institute of Drug and Alcohol, will be implemented at the following HBCUs: Morgan State University, Bennett College, Southern University (Baton Rouge), Fisk/Meharry University, Lincoln University, Langston University, and Jackson State University. NBWHP is providing training sessions and liaisons who will work with the schools. We will also be organizing self-help and substance abuse prevention policy advocacy groups, in the communities surrounding the campuses.

By now, you have received the double issue of Vital Signs on cancer education in the African-American community. The dedication to several NBWHP members makes this a special keepsake issue. This issue of Vital Signs features the health of older women. For all you authors, we welcome articles for future Vital Signs, please call, fax or write us for more information.

At the March Board of Directors meeting the decision was made to conduct a survey of the membership to determine the ways that we can improve our membership services. We know that there have been many difficulties and we aim to

correct those problems. We have hired a direct mail consultant who will be handling the mailings for membership renewals, appeals, and Vital Signs, but we need your ideas. Your opinion is valuable to us and will help us become more efficient in this area.

In our quest to provide skilled leadership to the National board, one of the first steps taken was to identify and appoint three new Board members with financial, legal, programmatic, and fund development expertise.

The following new board members will serve one year appointments: Lynn McNair of Washington, D.C.; Sharon Lovick Edwards of Houston, TX; and, Etienne R. LeGrand of Oakland, CA. Each brings a wealth of experience and technical knowledge that will greatly enhance our organization. Details regarding the proposed future process for submitting candidates for nomination and election of board members will be discussed at the Annual meeting. The Board also welcomed Sylvia Quinton of Maryland, as the Federal Liaison (a Department of Health and Human Services representative), to assist NBWHP in the coordination of joint activities related to the newly funded HBCU substance abuse prevention program.

Over the next year, as we work together to determine the course of action for our organization, we will evaluate and assess the work to be done, the required skills and expertise needed, and develop a process for the larger expansion of the Board over the next 3 - 5 years.

This year, our conference and annual meeting, ***Coming Back Strong - Walking for Wellness,*** will be held in Detroit. Details on conference registration can be found in this issue. In conjunction with our conference, we will highlight a new partnership between NBWHP, the American Heart Association, and the National Conference of Black Mayors, entitled ***Walking for Wellness: Protecting Hearts, Saving Lives***. This initiative allows us to work in a collaborative effort to promote physical activity and encourage taking care of the entire body. The plan is to take this model of *Walking for Wellness* around the country. The first two cities are Baltimore, which held its walk, May 3; and Detroit, which will hold its walk on June 28, as part of our national conference and meeting. We look forward to seeing you in Detroit.

Finally, while the National Office can offer technical support and expertise, share the philosophy and policies of NBWHP and provide direction for members to operationalize the vision and goals, this organization has always been member driven. *Every Black Woman is a Potential Organizer for the Black Woman's Health Movement.* The National Office should not and cannot put together a standard model for members in every state and city to deal with their own local and state issues. It is important, however, that each chapter/member notify the National Office when information or technical assistance is needed. If you or anyone you know has not been receiving mail from the organization, please fill out the self-help registery included in this issue or contact us with the necessary information so we can update our records.

We encourage members to take the initiative to utilize local resources to organize Black women in your communities around wellness activities. Empowerment comes through collective action and a feeling of accomplishment. It is through using our ***combined*** energy, creativity, intelligence, and spirit that we will continue to move the Black Women's Health Movement forward. This is how our organization began and will continue to grow.

In Sisterhood, Wellness, and Health,

Akua Budu-Watkins
Chair, Board of Directors

President's Report

Well....the theme of this issue - ***Black Women: Maturing Healthy and Wise*** - with its focus on older women has special personal and professional significance for me. Over this period of relocating and restructuring the national organization, and becoming a first-time grandmother of a beautiful baby girl, "Perri Jordyn Felder," I have felt blessed, challenged, and definitely much older!

As you might expect, there is good news to share, as well as, challenges to overcome. Most dramatically, the untimely violent death of our sisterfriend and administrative assistant, Ronda Adams, has affected us all very deeply. A special tribute to Ronda, in this issue, expresses the loss felt by staff, board, members and the many others whose lives were touched by Ronda.

Overall, the good news is we have survived the transition, begun developing procedures and processes to ensure a fiscally sound operation, and identified a work plan and staffing pattern to pursue our programmatic agenda that will take us into the 21st century.

Congratulations are in order for the two NBWHP programs located outside the national office as they move on to independent status: 1) The Center for Black Women's Wellness (CBWW), under the leadership of Cheryl Y. Boykins; located in the McDaniel Glenn housing project in the Mechanicsville area of Atlanta, has obtained its own tax-exempt status effective January 1, 1997, and 2) the California NBWHP state office, under the directorship of Holly Mitchell, is in the process of securing their tax-exempt status and has raised a record amount of funds for their program activities.

The Public Education and Policy program has maintained its program focus and is in the process of hiring staff. Major public policy issues we are working on include access to health care (managed care, Medicaid changes and its impact on preventive screening and wellness services), impact of welfare reform and reproductive health and rights (access to safe and effective contraceptive, infertility and abortion services, STD prevention, screening and treatment, voluntary confidential testing and treatment for HIV/AIDS), and breast care, etc.

New program initiatives NBWHP has embarked on this year include:

Student Organizing on HBCU Campuses
In 1997, NBWHP will participate in the development of a self-help/public policy advocacy demonstration project in collaboration with the Center for Substance Abuse Prevention Program (CSAP) on seven Historically Black Colleges and Universities (HBCUs). The NBWHP collaboration with CSAP is being funded by the R.W. Johnson Foundation. This initiative will facilitate the development of curriculum to train students in mentoring at risk youth and link activist self-help groups and chapters on college campuses with young women in the neighboring communities, to develop drug abuse prevention public policy strategies.

Walking for Wellness
NBWHP is working in collaboration with the American Heart Association (AHA) and the National Conference of Mayors to implement in the late spring of 1997, a major walking for wellness walk in two cities, Detroit and Baltimore. We urge all Detroit members to spread the word and contact your chapter for more information on how you, your family and friends can participate in the June 28th city-wide Walk.

These pilot programs will be the start of a national NBWHP walking program involving at least 10 cities in 1998. We encourage other NBWHP Chapters who are interested in participating as one of the 10 lead walking groups in the 1998 series to plan on attending the Walking for Wellness training session at the June conference.

Breast Cancer Awareness
NBWHP staff and members have been very active on breast cancer panels and committees over the past 5 years. As with other critical health issues our public policy and education work has focused on raising awareness on how we are differently affected by breast cancer. While black women have a lower incidence rate than white women we tend to get breast cancer at an earlier age (thirties and forties) and we have a much higher mortality rate (50% for women ages 40-49). Recent studies seem to indicate we might also get a more faster growing and aggressive form of breast cancer that is often not seen on mammography. NBWHP is proposing to develop a Breast Cancer Awareness Project aimed at prevention; identification and development of additional screening tools and public policy research initiatives.

Fundraising
One of the top priorities for the organization this year has been to increase and diversify our funding base. We appreciate our long-standing and new members who have kept current with their dues and responded to our additional requests over the last year as we strive to become less reliant on foundation (restricted) funds, which now comprise 85-90% of our funding base.

The generosity of so many of you have strengthened our ability to survive this long. One such blessing is Alice Walker, who, in conjunction with the publication of her newest book on activism, *Anything We Love, Can Be Saved*, generously offered the NBWHP the opportunity to use her D.C. book opening as a fundraising event. On April 28, 1997, we held a "Celebration of Activism," a gala event that honored Alice and her activism around several key social issues that the NBWHP works on. The event was spectacular, powerful, moving and spiritual. More information on this exciting event can be found later in this issue.

Annual Membership Meeting
There have been a number of organizational changes over the past year that we are anxious to share with you and get your input regarding the future direction of the organization. The next NBWHP annual membership meeting is scheduled for June 27, 1997 from 3 - 5 p.m. in Detroit, MI. Information on the site and agenda for the meeting can be found in this issue of Vital Signs. Important information on the organizational and programmatic changes; the criteria for submitting program and action proposals to be considered by the Board and the election process, will be presented at the annual meeting.

The process of relocating the national office during 1996 resulted in a significant decrease in contact with members. Since we did not have a national conference in 1996 (when most members traditionally paid their annual dues) you did not receive a reminder regarding paying your annual membership. In order to show our appreciation for hanging in there with us during this hectic time we have extended your membership year through December 31, 1996.

The NBWHP membership year is from January 1 to December 31. If you have not yet paid your 1997 dues you must be current in order to participate in the June 1997 membership meeting deliberations. If you do not know your dues status please call, fax or write us (before the June 1st deadline). A membership form is included in this issue with the current dues schedule.

This has been a challenging year and a half, but not once has our vision, of all we can be, been diminished or appeared unreachable. Collectively we, individual members, Board, staff and funders, continue to believe strongly in the need for and potential of a strong Black women's health and wellness movement. We can not do it alone. Only with your continued support and guidance will we move strongly into the twenty first century.

In Sisterhood,

Julia R. Scott

In Loving Memory of Our Sister-Friends...

Ronda A. Adams ...Forever Our Ronda Donda

December 2, 1970 - March 15, 1997

SISTER SPIRIT

You left us all too soon, girlfriend – we thought we had a lot of work to do together especially when times got good. Little did we know that you were the good times, your gentle smile, your shy demeanor, your youth and willingness to do whatever needed to be done.

Somehow behind your round quiet face you kept your reality from those who loved you. Your trusting nature kept you from believing that harm could surely come your way. You always saw the good in everyone even when it was over shadowed with evil and destruction.

Ronda, like so many other sisters you have left us all too soon. Too many women die every year at the hands of some jealous crazy lunatic....who still lives. Your daughter, the spitting image of you, stood at your casket for at least twenty minutes trying to make some sense of it all. Why..why..why there are no answers that make sense to us or can dry our tears.

We seek consolation in knowing that you were one of the sister spirits committed to the National Black Women's Health Project. We know that you have joined Ms. B. and the two of you have become powerful angels organizing all of the women who have made the transition and love the Project. We know you are singing, *we are the ones*. Minnie will teach it to you, she knows it very well. So when things start to magically happen, especially the events that we can't explain we know that the three of you are working it.

We feel your energy, your gentle, sweet sister spirit walking among us. We thought you left too soon, but what we know is that you were meant to be here only for a short time. We miss you and we will keep you in our memories. Your spirit still lives.

Axe and amen.

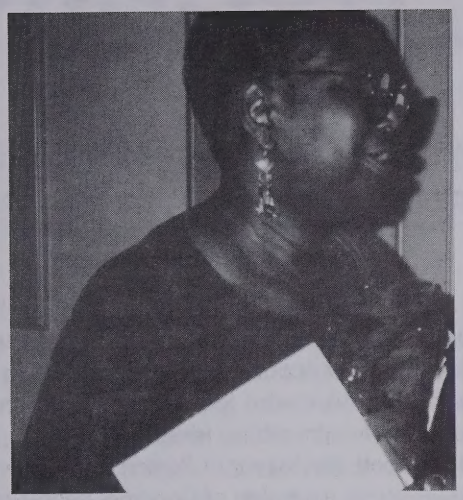
Your Sisters at the National Black Women's Health Project

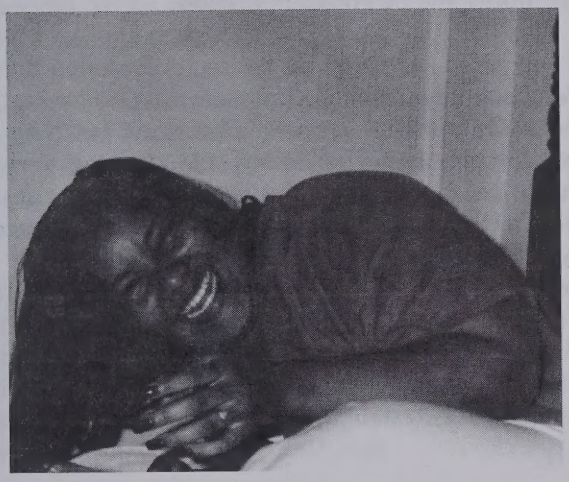
As you place **sister spirit** on the altar, think of someone whose spirit was extinguished by violence.

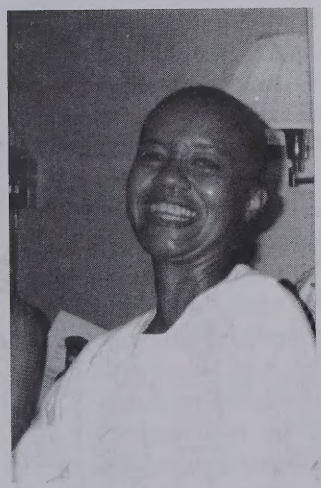
Affirmation: I am committed to ending violence in our society. I will start first with myself, as I connect to my own sister spirit.

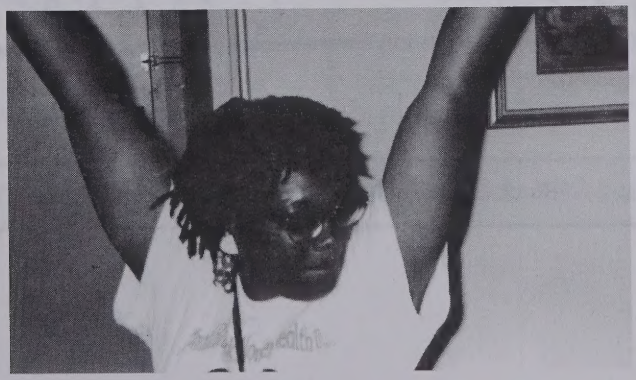
Quote: You never realize death until you realize love.

--Katherine Butler Hathaway
The Journals and Letters of the Little Locksmith









Mary Louise (Mamie) Tarby

January 3, 1896 - December 9, 1996

Mamie Tarby lived a full and vibrant life for more than a century. She never married or had her own children, but she created family and established life-long relationships with three generations of the children of those she loved. Many of us considered her mother, aunt, grandmother or beloved great-grandmother.

Mamie loved her family passionately. She was fiercely loyal, expected excellence, was encouraging and supportive (especially of the youngest among us), created and maintained scrapbooks on the achievements of the individuals in her "family," and forever explored the new, even while sharing her wisdom which was grounded in tradition.

Mamie was staunchly her own person. She took what God gave her and did the best that she could. It was important to her that her name be on one of the bricks on the foundation of NBWHP's Motherhouse. She was the first Black woman hired by Filenes to work with customers in their downtown Boston store. She worked there for more than a quarter of a century and before retirement was awarded their highest employee award.

Mamie died as she wanted to, at home among her things and in her sleep. Nine months earlier we held a fabulous 100th birthday party for her, with guests from all over the country, representing five (5) generations of those who loved her. Her birthday was not only recognized by friends and family, but by Willard Scott, the Mayor of Boston, the Governor of Massachusetts, a number of Congress people from her district and by President Clinton.

If you asked Mamie about her secret for longevity she would say: reading a daily newspaper, having the smallest possible personal pharmacy, watching her favorite basketball team play, taking her "medicine" (a shot of brandy drizzled with creme de menthe) with her evening meal, being surrounded by her "children," and the all-conquering power of love.

Mamie Tarby was my grandmother, my support, my confidant, and my friend. She held my hand when I took my very first steps, and she never, ever let go.

I love her and miss her.

Ngina Lythcott

High Blood Pressure and Congestive Heart Failure: Why African Americans Should be Concerned?

"My grandmother called it dropsy. Her mother, my great grandmother, died of it, I think. I visited her when I was very young, and the thing that I remember most is how swollen her legs and feet were. I have an uncle who has it now, too, and he can hardly get around. He has to prop up to breathe, so he sleeps on a big pile of pillows. It must run in my family."

Does this sound familiar? Almost everyone has known someone with these symptoms—a family member, a neighbor, or someone at church who struggles at first to get around and eventually has trouble getting from their bed to a chair.

The disease described, congestive heart failure (CHF), has been around for many years. It's depicted in art that is centuries old. However, CHF is not a disease of the past. Instead, it is a serious and growing health concern that prevents many people from fully enjoying their final years.

According to the National Health and Nutrition Examination Surveys conducted by the Centers for Disease Control and Prevention, about 4.8 million Americans have CHF. More than 1.4 million are under 60 years of age. CHF affects African Americans disproportionately; the prevalence of CHF among African Americans is at least 25 percent higher than among whites.

What is CHF?
Congestive heart failure occurs when the heart loses its ability to pump enough blood through the body. This loss of pumping ability is caused by damage to the heart muscle. Although the term heart failure suggests that the heart suddenly stops, CHF is a progressive disease that usually develops over a number of years.

What causes CHF?
The damage that initiates congestive heart failure can be caused by a heart attack, high blood pressure (also called hypertension), valve deformities, hardening of the arteries (also called arteriosclerosis), or lung disease. One of the most common causes of CHF is uncontrolled hypertension.

Why is hypertension a serious concern?
High blood pressure increases a person's risk of heart failure, heart attack, stroke, and kidney disease. High blood pressure is common in the United States, especially among African Americans. According to the most recent National Health and Nutrition Examination Survey, nearly 7 out of 10 African Americans age 60 to 75 have high blood pressure. This is the highest rate among all Americans and one of the highest rates in the world. High blood pressure can be treated, yet only one of four African Americans with high blood pressure is controlling the condition. We can and must do better.

How High Is High?

Your blood pressure is considered high if it meets or exceeds 140/90 mm Hg The top number or systolic measurement reflects pressure exerted by the heart on the arteries as it pumps blood. The bottom number or diastolic measurement is the pressure exerted when the heart is at rest.

Why is CHF increasing?
The aging process itself increases the risk of congestive heart failure and conditions that contribute to it. We are seeing more CHF because people are living longer. Our ability to save more people who have a heart attack or a stroke also has

increased the number of Americans who eventually develop CHF.

How serious is this epidemic?
In contrast with other heart diseases, the rate of congestive heart failure is steadily increasing. Between 1968 and 1993, the number of Americans wit*h CHF more than quadrupled. In addition, deaths attributed to CHF have not declined. In 1993, more people died of CHF than died from AIDS complications. The rate of death from CHF was nearly 1.5 times higher among African Americans than whites.

As shown in the figure, the hospitalization rate for CHF has increased fourfold over the past 25 years. For people age 65 and older, CHF is now the most common diagnosis listed at the time of hospital discharge. Thus, it also is the most expensive item ($12 billion) in the Medicare budget.

Although CHF is a serious public health concern that warrants national attention, we can improve the quality of life for CHF patients. Prevention remains the best way to fight this condition.

What is being done to prevent CHF?
The most effective way to prevent congestive heart failure is to prevent and control high blood pressure.

"It is critical for health professionals and the public to become actively involved in preventing and controlling high blood pressure,"says Dr. Edward J. Roccella, coordinator of the National High Blood Pressure Education Program (NHBPEP) of the National Heart, Lung, and Blood Institute (NHLBI). "We know that high blood pressure is one of the major causes of congestive heart failure, and we also know that high blood pressure can be prevented and controlled. In fact, clinical trials have shown that controlling high blood pressure can reduce congestive heart failure by 55 percent."

High blood pressure can be treated; however, people often fail to take their blood pressure medicine over the long term, and many people do not even find out that they have high blood pressure until damage has been done.

In March 1996, the NHBPEP issued a national call for action that urged its 45 member organizations to help convince heath professionals and the public of the importance of preventing and controlling high blood pressure, especially in older Americans. A network of agencies that reach older Americans through community outreach efforts has been developed. This network, which includes the National Black Women's Health Project, will help the NHBPEP reach more people with information about preventing and treating high blood pressure and CHF.

The NHLBI supports a wide range of research studies aimed at improving our understanding of CHF and developing better methods of preventing, diagnosing, and treating this disease.

What can I do?
Although African Americans have an increased risk of high blood pressure and thus a greater chance of developing congestive heart failure, these conditions are not inevitable. You can do many things to reduce your risk of hypertension and CHF. These

Symptoms of Congestive Heart Failure

- Fatigue and weakness
- Shortness of breath all the time or during mild activity
- Swelling, especially in the legs or ankles
- Rapid heartbeat
- Dry, hacking cough or wheezing
- Waking up suddenly with a feeling of suffocation
- Trouble sleeping unless propped up on several pillows
- Weight gain (from fluid retention) of several pounds in less than a week—sometimes in a 24-hour period

actions include reducing the amount of salt in your diet, exercising regularly, maintaining a healthy weight, and limiting your alcohol consumption to no more than two drinks each day. To reduce your overall risk of cardiovascular disease, quit smoking. It is never too late to benefit from this important behavior change.

It also is essential to have your blood pressure measured on a regular basis and to encourage family members and friends to do likewise. Older people, who are at particularly high risk for both high blood pressure and CHF, may need your help making a doctor's appointment or getting to the doctor's office or clinic. They also may need someone to write down important information that they may otherwise forget to share with their health care provider, such as symptoms they have experienced, medications they are currently taking, and questions they want to ask the doctor.

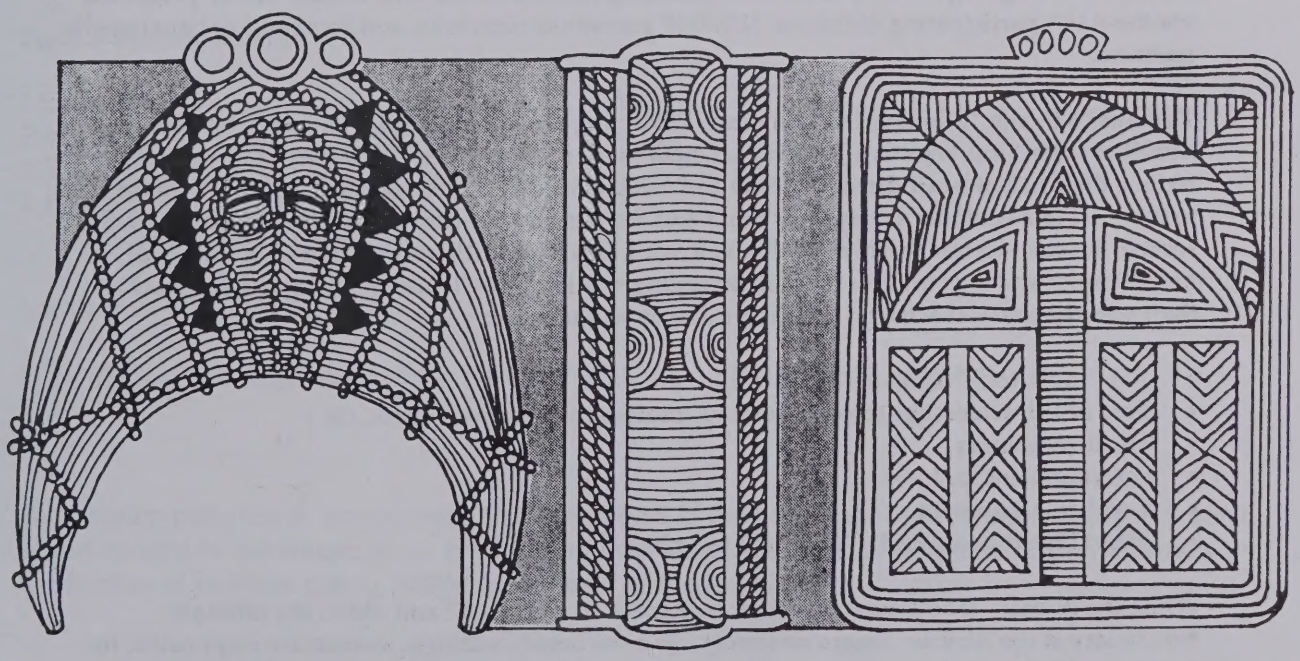
If you find out that your blood pressure is too high, remember that it is very important to work with your doctor and faithfully follow your management plan. Stay on treatment, even if you are feeling good. High blood pressure should *never* go untreated.

Where can I get more information?
The National Heart, Lung, and Blood Institute offers free information on high blood pressure and congestive heart failure, including ways to prevent these diseases.

You can request information by writing to the NHLBI Information Center, P.O. Box 30105, Bethesda, MD 20824-0105, or call (301) 251-1222. Or you can hear messages concerning high blood pressure and request information by calling (800) 575-WELL.

If you have access to the Internet, the NHLBI provides information through its World Wide Web site (http://www.nhlbi.nih.gov/nhlbi/nhlbi.htm) and through a Gopher Browser (gopher://fido.nhlbi.nih.gov:70/11/nhlbi).

Co-Authored by
The National High Blood Pressure Education Program
and
The National Black Women's Health Project

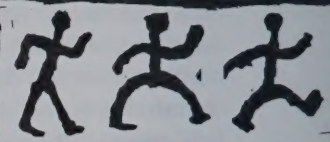


Walking For Wellness

Protecting Hearts, Saving Lives.SM

THE NATIONAL BLACK WOMEN'S HEALTH PROJECT

American Heart Association℠
Fighting Heart Disease and Stroke



African-American Women: Walking For Wellness 1997
"Protecting Hearts, Saving Lives"

Walking For Wellness: Protecting Hearts, Saving Lives is a community-based program that has been developed to encourage physical activity and preventive care of the entire body. The event was created through a partnership between the American Heart Association and the National Black Women's Health Project, with support from the National Conference of Black Mayors. Walking For Wellness events will be held in Baltimore on May 3 at Druid Hill Park from 10 a.m. to 2 p.m., and in Detroit on June 28 at Belle Isle from 8 a.m. to noon. Expanding on the framework of the NBWHP's successful self-help walking programs, the events are not designed as a fund-raiser, but rather a fun, non-threatening forum for health education on a number of issues including: heart health, nutrition, obesity, physical activity, high blood pressure, high cholesterol, smoking, etc.

The goal of the event is to improve the health status of Black women by encouraging Black women, their families, and communities to take the initiative to improve and safeguard their health on an ongoing basis by establishing lifelong healthy habits. The events will be promoted via the AHA participating divisions, NBWHP grassroots networks, and local and national media partners.

This year's theme "Walking For Wellness: Protecting Hearts, Saving Lives" and the days activities reflect our objectives. Each participant will receive the health information needed to reduce their risk of heart disease, stroke and other diseases. Receiving such information can lead to the start of a healthier lifestyle for them and the people they care about. Individuals will also receive an easy-to-use Personal Wellness Record complete with information on a variety of health topics and logs to record health screening results. They'll also get a log to keep track of their weekly physical activity. The days events will include:

- A 1-3 mile walk (kicks off the event)
- Free health screenings (blood pressure, cholesterol, glucose, fitness, etc.)
- Health Seminars
- entertainment for kids
- Local entertainment
- Heart Healthy (or nutritious) snack sampling

While the primary target market is African-American women 12 and older, the ultimate beneficiary is the African-American family. In most family settings, women are responsible for family health issues, the purchase and preparation of food goods, and in many African-American homes serve as the head of the household. Thus, activities and health information for men, women and children will be part of the day's events. The printed educational material will be disseminated at the walks and then later throughout the year at health fairs, conferences, etc. by the AHA and the NBWHP.

Walking for Wellness
Program Interest Form

These forms should be completed by individuals who are interested in establishing a walking group at a specific location. They should be returned to the following address:

Walking for Wellness Program
National Black Women's Health Project
1211 Connecticut Avenue, NW
Suite 310
Washington, D.C. 20036

Name: .....

Address: .....

City, State: .....

Zip Code: .....

Telephone #: .....

Type of Walking Program

1.Community .....
2.Worksite .....
3.School .....
4.Other .....
(Please Specify)

Location of Walking Program: .....

How did you become aware of the NBWHP Walking for Wellness Program?

.....

All program participants are expected to be members of the National Black Women's Health Project. Upon receipt of minimum of six program interest forms and membership application and fees (or verification of member status), NBWHP will mail to the identified lead walker an instruction manual.

Sister, Sister

Quieting Our Fears: Lesbian and Aging

In my practice as a therapist, young lesbians – especially those who are just ending a relationship – often express dread and horror at the prospect of growing old as gay woman. Most of us probably share their fears that old lesbians are asexual and have no family or stable lover relationships. We assume lesbian women have little in common with heterosexual women their age, are isolated from their peers, and are reluctant to use senior social services. We end up with the commonly held profile of an aging lesbian: lonely, bored, and depressed.

The facts paint a far brighter picture.

Although some information about lesbian and gay aging has been published in professional and academic journals, much of it is still unfamiliar in the lesbian and gay community itself. In 1975, I co-directed a National Institute of Mental Health (NIMH) study of 97 people over the age of 60 – lesbians, gay men, and heterosexual men and women. We compared life satisfaction, physical and psychological well-being of the four groups.

While significant, the NIMH study was limited in terms of racial diversity and number of participants. Today, for a variety of reasons, old lesbians are reluctant to participate in psychological or social research; 10 years ago it was even harder to find respondents. When we advertised for the study, for example, we were deluged with calls from old gay men; not a single old lesbian responded. So we found our lesbians respondents mostly through word of mouth–through friendship networks and support groups.

From 1984 to 1986, interviews were conducted with hundreds of old lesbians for an anthology of their stories called *Long Time Passing*. The portraits that emerged from both the study and the interviews contradict the fears about what lesbian life over 60 is all about. Old lesbians are active, vibrant women with supportive friendship networks and passionate lover relationships. The myths turned out to be just that.

Fear: Lesbians grow old alone.

Reality: Denied access to societal support for lover relationships, and often alienated from families of origin, lesbians create extended families from friends and ex-lovers. Support networks serve us well as we grow old. Lesbians in the study had been in an average of six relationships, lasting a total average of 31 years–which means that as adults, they are rarely without a partner. Sixty-four percent of the lesbians in the study reported that ex-lovers were their oldest and dearest friends, their "families of choice" with whom they celebrate holidays and anniversaries. By comparison, none of the heterosexual women reported ongoing relationships with ex-lovers or ex-husbands.

For heterosexual women, physical and emotional intimacy often disappears when their husbands die. Lesbians' chosen families are a resource for maintaining intimacy–with or without a surviving spouse–throughout their later years.

Fear: Lesbian relationships don't last (so old lesbians don't have lovers).

Reality: For most heterosexuals, creating an economic unit and having children are important factors that motivate and sustain marriage. Lesbians, however, do not establish long-term relationships for these reasons (even though Lesbians may pool incomes or decide to raise children together). Lesbian bonding is based on needs for affection and intimacy.

Of the lesbians in the study, the average length of of time of their longest lover relationships was 13.2

+years. In another national study, conducted in 1980 by Cheryl Goldberg, lesbians reported an average longest relationship of 15 years.

Given the current median duration of 20 years for heterosexual marriages, and the difficulties of maintaining a lesbian relationship within a hostile culture, what is amazing is not that lesbian relationships are so short-lived–but that they are so long-lasting!

Fear: Old lesbians are not sexually active.

Reality: In our study, 52 percent of the lesbians were sexually active, compared to 24 percent of the heterosexual women. Sixty-eight percent masturbated, compared to 36 percent of heterosexual women. For all four groups in the study, the average frequency of sexual contact was three and a half times per month. This is consistent with JoAnn Loulan's 1987 study of lesbian sexual frequency, which also reported an average of three and a half times per month after age 60.

Fear: Lesbianism leads to a miserable old age.

Reality: Much has been written about the mid-life crisis of heterosexual women: the empty nest syndrome, the breakup of long-term marriages (often after a husband gets involved with a younger woman), and the displaced homemaker entering the paid work force for the first time.

For lesbians, aging is less of a radical rupture. There is no sudden shift from family to work world; we often have been financially self-sufficient for much of our adult lives. For those who lived closeted gay lives, retirement may bring liberation from the need to pass, along with the freedom to participate in the lesbian community. Unlike the heterosexual husbands, the lesbians in our study preferred partners similar in age–which means lesbians are less at risk for being left for a younger partner. And, without the heterosexual expectation of one partner "till death do us part," old lesbians are better prepared to begin new lover relationships at any age.

Fear: Old lesbians are powerless.

Reality: There are now service programs providing social, legal, and in-home assistance to older lesbians.

Senior Action in a Gay Environment, Inc. (SAGE)
208 West 13th Street, New York, NY 10011 (212) 741-2247
-Free social, counseling and support (including HIV services) for older lesbians. Drop in center.

Older Lesbians Organizing Committee:
219 Farmstead Lane
Lansing, MI 48917
(517) 886-9941 (517) 886-9934 (FAX)

Older Lesbians Organizing For Change
P.O. Box 980422
Houston, TX 77098

Mammography Controversy

NIH Consensus Panel Recommends Women Make Individual Decision

After nearly four years of on-again, off-again debates, mammography is once again hot news in the wake of a controversial new report by a National Institutes of Health Consensus Panel.

The Panel recommended insurance coverage of screening mammography for women in their forties be screened regularly. The Panel's less than enthusiastic support for mammography screening of young women was somewhat surprising, as the Panel was convened at the request of Richard Klausner, the new National Cancer Institute (NCI) Director who has been pressured by Congress to come out in favor of routine screening for women in their forties.

The Panel's recommendations were instantly controversial when the report was released in an NIH auditorium in Bethesda, Maryland in late January. Radiologists responded vehemently, claiming that the report was a "death sentence" for thousands of women and that panel members were hand-picked by NCI scientists biased against mammography. A well-known Swedish radiologist, Lazlo Tabar, rushed to the microphone to claim that an epidemiologist critical of mammography "didn't know how to count."

The National Women's Health Network (NWHN) Executive Director Cindy Pearson staunchly defended the panel's refusal to make a blanket recommendation when the data doesn't warrant one, stating, "It is way past time to stop giving women simplistic information in order to control their behavior. Women deserve to know everything that researchers know, even if it is not clear cut." (In 1993, the Network issued a recommendation that women begin screening at the time of menopause, or age 50, whichever came first.) Other consumer advocacy organizations including the Center for Medical Consumers and the Long Island One in Nine Breast Cancer Group commented favorably on the Panel's work. Further fueling the controversy, NCI's Director publicly disagreed with the conclusions of the Consensus Panel.

The radiologists' point of view; Klausner's renunciation of the panel's decision; and the decision of the American Cancer Society to continue recommending screening for women in their 40's galvanized the Senate, led by all nine women Senators, to pass a non-binding resolution in early February, strongly encouraging NCI to recommend screening for women in their forties. The measure passed by a vote of 98 to 0, demonstrating either that every Senator is deeply concerned about breast cancer, or that at least some senators perceived this as a no risk, no thought way to be seen as supportive of women. At a Senate hearing shortly after the vote, Fran Visco, President of the National Breast Cancer Coalition, confronted Senators, saying "Let's save outrage for the fact that we don't know how to prevent this disease, how to detect it truly early, or what to do for an individual women once we do find it." So far, we've seen no indications of a broader legislative response.

What are the Facts Behind the Controversy?

The need for good breast cancer screening tests for women under 50 is real. Over 22% of all cases of breast cancer are diagnosed in women under 50. Although the average 40 year old women has less than a 2% chance of being diagnosed with breast cancer in her forties and only a 0.3% chance of dying while in her forties, breast cancer is still the most common cause of death for women in this age group. African American women are especially affected by the need for a good screening test for younger women; on average they are 7 years younger when diagnosed with breast cancer than are white women. Eight randomized controlled trials have evaluated the ability of mammography screening to save women's lives. Taken together, these trials show a significant benefit for women 50 to 69 years. Within seven years after beginning screening, women are 30% less likely to die of

breast cancer, a benefit which seems to persist as long as women are followed (nearly 20 years in the oldest study). These trials have also included women under age 50, and until now, did not show a life-saving benefit for younger women. Now that several trials have followed women for 10-14 years and even longer, there is a statistically significant mortality benefit for women who were in their forties when screening began. Published estimates of this benefit show a decrease of about 16%. At the Consensus Conference estimates based on newly reported data were closer to 18%. In most cases when a group of randomized controlled trials shows a statistically significant reduction in mortality in the screened population, recommendations are made for routine screening. But in this case, the Consensus Panel looked at the data and came up with a different recommendation. One major reason for their decision was the length of time it took for any trial to find a benefit in women in their forties. If it takes 10 or more years to see a decrease in mortality in women who began screening at age 40 (or 45 in at least one trial), then it is likely that at least some of that benefit is from screening that took place after age 50. The Panel also took into account that even though a small mortality benefit had been demonstrated, the test was clearly not as good in younger women as in older women, partly because breast tissue becomes less dense with age, particularly after menopause. While mammography misses about 10% of invasive cancers in women over 50, it misses 25% of invasive cancers in women in their forties. Women in their forties are at least as likely as older women to be told they have a suspicious mammogram, but are much less likely to have a cancer found during follow-up–the mammogram is more likely to give a false positive result. Another factor considered by the Panel is the likelihood that women in their 40's will be diagnosed with ductal carcinoma in situ (DCIS). It is not completely clear yet whether this is bad news or good news. Only invasive cancer has the capacity to metastasize and kill. If all DCIS were destined to evolve into invasive cancer, catching it at the pre-invasive stage would be beneficial. But studies have shown that the majority of DCIS does not develop into invasive cancer, leading the Panel to raise the issue at routine mammography screening for women in their 40's may lead to significant unnecessary treatment including bilateral mastectomies. The Panel also raised the issue of the theoretical risk of cancer caused by mammography. Although it is well established that higher doses of radiation at earlier ages can cause breast cancer, the risk from low dose mammography starting at age 40 is not established.

What You Can Do?

We encourage women to get as much information as possible. We are preparing a fact sheet about mammography, which will expand on the information in this article. We also encourage women to become active with groups working for more research on alternatives to mammography, more information about the causes of breast cancer, better treatments, safe prevention and access to health care for all. The final version of the Consensus Statement should be available from NIH in late March. Call 1-800-4-CANCER.

Cynthia Pearson, Executive Director, National Women's Health Network

Perspectives of an African American Panel Member

A significant number of our members have been and are now afflicted with and affected by breast cancer. Our last Vital Signs®, NBWHP's newsmagazine, was dedicated to sisters we have recently lost to cancer, especially breast cancer. Our public policy program has been in the forefront of pushing the women's community and legislators to acknowledge the differences in the way breast cancer affect African American women, i.e., we have a lower incidence than white women but get breast cancer at an earlier age (30-45) and have a 50% higher mortality.

We too felt outrage when the mammography screening guidelines were changed in 1993 from age 40 to 50, and continued to advocate for a screening tool that would help African American women find breast cancer early. As we learned more about the limitations of mammography in

picking up the types of cancer found in younger women i.e. faster and more aggressive type cancers than the type found in women after age 50, we felt there needed to be more research on the causes of cancer with a focus on prevention and on other types of technology for screening.

Recently, I had the opportunity to participate as a member of the NCI Breast Cancer Screening Consensus Panel that deliberated on this issue in January 1997. I was one of only two (non-scientist) constituent representatives and the only African American on the Panel. While NBWHP did not have a position advocating for or against required mammography screening for women in this age group before this meeting (a stipulation required of all members of the panel); we clearly were seeking to find any data that might support mammography screening being a benefit for African American women, given that we are affected differently than White women by this disease.

After carefully reviewing over 150 research articles on the issue and listening and questioning for one and one-half days the data from researchers who conducted the eight randomized controlled trials, the Panel came to the only conclusion it could given the data it had. We did not have the luxury to consider just one study that supported our own bias or to consider data not included in the consensus meeting.

Clearly mammography has been shown to be effective in reducing breast cancer mortality in women ages 50-69. However, current available evidence from randomized controlled trials for women ages 40-49 following initiation of screening, indicate breast cancer mortality is no lower in women assigned to screening than in controls (those who had no screening). Evidence seems to be leaning towards showing some benefit, after 7-10 years, for women in their late forties (45-49) but not for women in their early forties.

Given the lack of evidence to support a universal recommendation for mammography screening of all women ages 40-49 the panel concluded, rightly I believe, that each women should have access to the best possible relevant information regarding the risks and benefits, presented in a useable and understandable form and make her own decision, based on her own values, whether to undergo screening mammography in her forties. As an organization of women we know women receive and can understand complicated information and make difficult decisions every day.

Of great concern to me as the only African American women on the panel was the fact that almost all the data available and reviewed were from studies done in Europe on White women. None of the studies reflected the diversity of women in the U.S. While I felt the lack of data on African American women and other U.S. women of color was a significant finding for the panel to include in the report, I believe that had there not been an African American woman on the panel this fact would not have been raised or, if raised not kept in the final document.

Many of us have been lulled into a false sense of security regarding protection from/detection of breast cancer by mammography screening only. Most abnormal mammographies do not signify cancer and it does not pick up 25% of the fast growing cancers which include the type of cancers that younger (mainly African American) women get. In addition, mammography is not an effective screening tool for women with dense breast tissue, regardless of their age. In other words, mammography has limitations and does not seem to be the screening tool that will help those women who have aggressive fast growing cancers.

Instead of using energy and influence to push for yet another reevaluation of the data join us in demanding more research funds to: 1) conduct the necessary randomized controlled trials in this country with adequate representation of the diversity of women in the U.S.; 2) develop effective screening technology for younger women and other women at high risk; and, 3) most importantly, find the cause and cure for breast cancer.

Julia R. Scott, President/CEO,NBWHP

The GW Mammovan: Driving Past the Barriers to Mammograms

"It hurts."
"It's embarrassing."
"Breast cancer doesn't run in my family."
"I don't have time to get a mammogram."
"My doctor never told me to do it."
"I can't afford it."
"I don't want to know my results."

Are these merely excuses not to get a mammogram? Or are they real barriers? Much has been written about why some women do not have an annual screening mammogram. There are statistics and reports describing the behaviors of groups divided by race, economic status, even sexual preference. Knowing how and why some women react as they do has been a good start toward finding ways to helping them overcome barriers.

There are studies and theories about barriers, and then there is the George Washington (GW) Mammovan. For the past nine months, this mobile mammography program of the GW University Breast Care Center has been driving through both excuses and barriers to get screening mammograms to women who otherwise would not or could not have one.

"We bring the van as close as possible to where women work or live," says Jean M. Lynn, program director of the Breast Care Center and mobile mammography program. "Then we reach out to each woman individually, to help her through whatever barriers about a mammogram that she perceives. And we do a lot of educating."

The GW Mammovan was launched in September 1996 and is sponsored by the Cancer Research Foundation of America. The van's mandate is to bring screening mammography to both corporate and community women of the District, Maryland, and Virginia. The program has received over $50,000 in grant monies to provide free mammograms and any necessary follow-up treatment to uninsured and under insured women. Recently, the program received a community service award from the Washington Metropolitan Public Health Association.

By all accounts so far, the program has been successful. "We have screened over 1,000 women to date and we are booked for site visits through October," notes Ms. Lynn. "We have found five cancers. I think we have been making a difference since we started."

Ms. Lynn believes the program is actually built one mammogram at a time. With the access and time constraint barriers virtually eliminated, she and her staff concentrate on getting women past other barriers.

Fear is still the biggest, say the Mammovan staff who make patient appointments. Listening to them on the phone with patients as they gently describe the process, make friends with each woman, and answer questions, you can hear a lot of comforting on GW's end of the phone. All that communication at the beginning also assures a very low "no-show" rate the day the Mammovan arrives.

Yet women still need to make the call. Just letting people know the van is due to come to a location near them, whether it's their church, workplace, or local YMCA, does not guarantee women will immediately head to their phone to make an appointment.

What has worked best for the Mammovan program is a lot of one-on-one attention. "Good old-fashioned peer pressure works very well, especially from breast cancer survivors," says Ms. Lynn. "Persuading women to come with a friend, sister, or mother also makes women feel comfortable. Sometimes we hear from a husband or male partner who wants the woman in his life to have a mammogram." The Mammovan staff also includes an outreach specialist who is on hand to educate women about early detection and talk about the Mammovan.

Here is how the program works. The van is scheduled to visit corporations and community sites,

arriving at a different site each day. Women call GW to make their appointment in advance, and are asked for information such as name, address, age and breast health history. Approximately seven working days after the appointment, the woman receives her results by mail. If there is an abnormal result and a need for referral, she will be called by either Jean Lynn or the technologist who took the mammogram.

The van itself is furnished like a comfortable doctor's office, with carpeting and wallpaper. There are dressing rooms with doors that close, an examination room, and a waiting area. The mammogram appointment takes about 15 minutes.

"Breast cancer can't be prevented, but with screening mammography we have a chance to detect it early," says Jean Lynn. "The Mammovan makes quality screening mammography accessible, affordable, and fast. For every barrier a woman has, we think we've got a solution."

(If you would like more information about the GW Mammovan program or a schedule of upcoming sites where the van will be, please call (202) 994-7703.)

Study Reveals Mammography Successes but Some Gaps in Care Remain

A survey about mammography utilization among older women, just released by the National Policy and Resource Center on Women & Aging at Brandeis University, shows that major breakthroughs can be made when state and federal government work with women and their advocacy organizations to make preventive care more accessible.

Almost 500 older women were interviewed in the Emergency Department at Boston City Hospital, where care is provided for many low income and minority neighborhoods. The women were asked questions about available health care services, breast care, breast cancer, and their attitudes toward mammography. An astounding 80 percent of these women reported a mammogram at some time in the past, and 73 percent of those who utilized mammography had done so within the last two years! These extremely encouraging numbers are at least 20 percent higher than rates reported by any national survey. Moreover, the mammography rates for African American women, (who nationally have had the highest mortality from breast cancer but the lowest rates of screening) were even a bit higher than those for the white women in the Boston City Hospital study and are consistent with the finding of an earlier study that found Massachusetts to be one of the few states in the nation to achieve equal or better mammography rates for African American women.

Why has Massachusetts been so successful in promoting mammography among older women and eradicating racial differences in mammography use between Black and white women? Four factors have worked together to make this achievement possible:

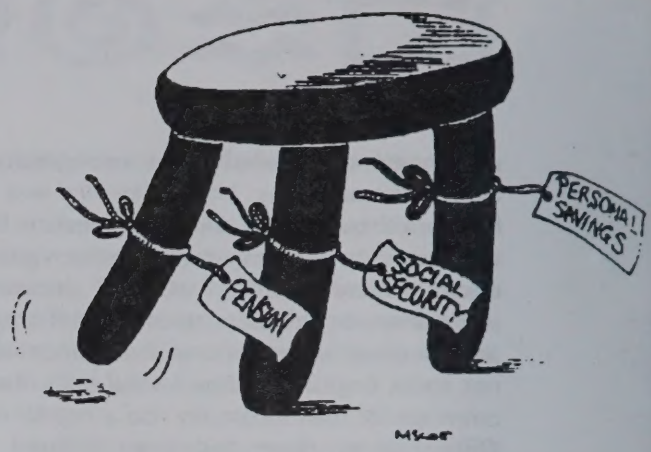
- federal action that (1) provided a new Medicare benefit for mammography screening every two years; and (2) initiation of a program to assist states with breast and cervical cancer detection by the Centers for Disease Control;
- the development of a Massachusetts Breast Cancer initiative – funding research and promoting consumer mammography education.
- the development of active state and local health education outreach networks;
- and finally, and probably most important, the creation of the "Free Care Pool," which provides state funds to reimburse hospitals for uncompensated, or free care. Under this program, many women who have no insurance, or who cannot pay the Medicare deductible, are eligible for assistance. As a result, economic barriers to preventive care for older women have been greatly reduced.

The survey did find, however, some significant gaps in care. Women who were not primary English speakers–mainly women originally from Spanish speaking islands in the Caribbean, from Haiti, and from the Cape Verdean islands off the coast of Africa–had dramatically lower rates of

mammography, referral for mammography, and clinical breast exams. Little difference was found between these women and those speaking English with regard to personal characteristics, visits to the doctor, breast cancer worries, accuracy of information about breast cancer risk and prognosis, and mammography concerns. But women who did not speak English at home lacked both insurance coverage for mammography and a regular doctor. Only half of them had been referred for a mammogram at any time in their life, and only 61 percent had ever had a mammogram.

This Center study documents the successes that have been achieved and identifies those groups of women not receiving optimal care. The Center is exploring ways to work with providers to increase referrals for mammography and to publicize the effectiveness of the "Free Care Pool".

For more information about the Center study, call the *National Policy and Resource Center on Women & Aging* at 1 (800) 929-1995.



"Why Women's Work is Never Done"

Many women still leave their jobs with a bouquet of flowers rather than a pension, because by the time older women recognize the importance of pensions, it's usually too late.

"If I had one thing to do over, I would have started thinking about retirement when I was much younger, says 60 year old Eileen Sorenson. Divorced after 30 years of marriage and raising three children, she works at a small community college in an entry level position. She knows that unless she wins the lottery she can never retire.

Today, despite their greater contributions to the paid work force, the majority of women workers do not have access to a private pension plan. Those lucky enough to have a pension are still likely to be penalized by the way the pension system effects women.

For the past forty years, policy experts have used the example of a three-legged stool to represent the sources of income that are needed for retirement security: an employer-provided pension, a social security worker benefit, and individual savings. Each of these sources of income is essential for a secure retirement.

But here's the reality check: most women do not have either pensions or savings. While women's participation in the labor force has increased substantially, their participation in pension plans has not increased at the same rate – women are still only half as likely as men to receive pensions. And since three out of four working women earn less than $26,000, even today's working women are unlikely to be able to save the significant amounts that are needed for retirement. Currently, only thirteen percent of older women receive pension income and the median income from savings is only $840 a year.

That leaves Social Security, as the primary source of income and a wobbling, one-legged retirement stool for most women. But here's the problem: the Social Security program was designed only to provide a bare minimum or a "floor of protection". In 1996, the average Social Security benefit for retired female workers was $7,452 a year ($621 per month) – $143 above the official poverty level for the elderly.

While the overall poverty rate for the elderly has improved over the past few decades, older women are still twice as likely as older men to be living near or below the poverty level. And unfortunately, the incidence of poverty continues to increase with age: the poverty rate for women of color is almost 2 ½ times greater than for white women. For Black women age 75 and older, the poverty rate is 43 percent.

Consider the story of Lorinda Wilkins: at age 90, she is willing to continue working but knows no one will hire her. "After working my whole life, I never thought I would end up with so little. I have never needed welfare and I don't want it now, but I don't have enough money to pay my bills,"

charged Mrs. Wilkins at a Boston Forum on Women's Retirement Security.

Mrs. Wilkins spent almost all of her adult life employed as a sales woman and an elevator operator. But none of the jobs that she held provided her with a pension benefit so, she had to rely on her husband's pension. Yet, when he died a few years ago, his pension suddenly stopped. Her story is typical, she was overworked and underpaid and now she is living in poverty after a lifetime in the paid labor force.

How do women like Lorinda Wilkins get so short-changed by the retirement system? For starters, the major reasons are related to women's employment patterns – women are concentrated in low-wage, service, part-time, non-union and small firm jobs, where pensions are less likely to be offered. Three out of five minimum wage workers are women. Women also change jobs more frequently and they earn less than men.

Finally, the retirement system does not account for the fact that care giving roles mean that women are less likely to receive benefits – the average woman spends 11.5 years out of the paid workforce caring for children and parents. But the paid care givers are usually in the worst financial position. Their employers not only do not provide pensions but often they do not contribute to the Social Security system, leaving many paid care givers completely out of the retirement system.

All of these factors eventually translate into severe financial problems at a time when many of these women find that their health is beginning to deteriorate and they are most in need of "retirement" income. In fact, care givers (as well as other low-paid women) are often forced to continue working long past the normal retirement age of 65 because they have so little income.

Yet, women need adequate benefits even more than men do because women live longer and they are more likely to live out their lives alone. While many women rely on a spouse's pension it may never materialize. One-third of women who become widowed are younger than age 60 and widowhood can devastate a woman's economic prospects – 80 percent of widows living in poverty were not poor before their husbands died. Only 21 percent of widowed women receive a survivor's pension. And divorced women are even worse off – many women (as well as their lawyers) do not understand the rules for including the husband's pension benefits at the time of the divorce.

While retirement issues are still a "sleeper" issue for most Americans, what it may mean for many women is a future shock. So what can women do? Well, one of the key aspects of retirement planning is to save early – the financial wizards advise that when you get that first paycheck you need to start saving steadily and of course, keep it for retirement **not** for other emergencies. We all know that's not easy and in order to save money of course, you have to make money.

But what about the women who work where the pay is low and there are few if any benefits. Women need to get the answers to a few simple questions now, so they are not surprised when they leave their job or when they retire. They need to learn how the pension system works, and how they can benefit most from the system. Find out how long it takes to become eligible to join the pension plan? Does the pension plan cover part-time workers? Does my spouse have a pension plan? What do I have to do to make sure that I will receive a widow's benefit?

And women need to support reform. Senator Carol Moseley-Braun (D-IL) is the first woman in the history of the U.S. Senate to sit as a permanent member of the powerful Senate Finance Committee - the committee that oversees pensions, Social Security and the tax laws. During the last Congressional term, Senator Moseley-Braun introduced two major bills, the Women's Pension Equity Act of 1996 and the Comprehensive Women's Pension Protection Act of 1996. Three of the six provisions included in the Pension Equity Act became law, and they further simplify the pension system for widows and divorced women.

The second bill recognizes specific gender

inequities in the nation's retirement system. "I want to make certain that the debate includes a reality check on the status of women, we should focus on making participation in private pension plans easier, and not the game of roulette which all too often leaves people surprised at their retirement," states Senator Moseley-Braun.

The only way that the retirement profile for future generations will change is if the women's advocacy groups join together to educate and alert their members to focus on retirement issues and by supporting the provisions that will protect women's long-term financial security.

Cindy Hounsell, Executive Director of WISER, Women's Institute for a Secure Retirement.

TEN IMPORTANT TIPS

1. Read the Working Women's Pension Checklist and Guide to the Checklist. Contact: WISE, 1201 Pennsylvania Avenue, N.W., Suite 619, Washington, D.C. 20004, (202) 393-5452, Fax (202) 737-7724.
2. Find out what your social security benefit will be.
3. Establish a budget.
4. Reduce your credit card debt.
   National Center for Financial Education (619) 232-8811 Box 34070, San Diego, CA 92163, is a non-profit that helps people learn how to spend and save their money.

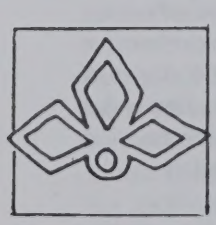
   Contact: Debra Zapper at (703) 481-1110. For $10, you can get a personalized report that shows you how much to pay on each card each month until they're all paid off.

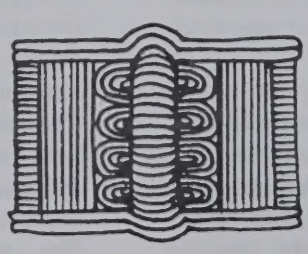
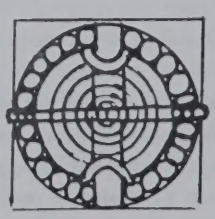
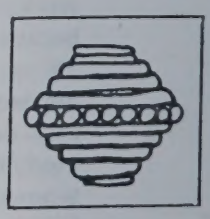
   Finding the best credit card:
   $4 to Bank Holders of America
   560 Herndon Pkwy, Suite 120
   Herndon, VA 22070 (703) 481-1110

   or

   $5 RAM Research, Cardtrak Newsletter
   Box 1700
   Frederick, MD 21702 (800) 344-7714

5. Pay yourself first. Safeguard the money you have already saved.
6. Participate in your employer-sponsored plan.
7. Buy Disability Insurance.
8. Make IRA contributions.
9. Evaluate your job in terms of the complete compensation package.
10. Learn more about your partner's income and pension.



AIDS AND OLDER ADULTS

Fourteen years into the AIDS epidemic in this country, health care providers and activists still complain of an inadequate response on the national, state and local levels. As infection and mortality rates soar with little hope of a cure or vaccine, the HIV/AIDS community struggles to hold its ground. The work now being done by thousands of volunteers, professionals and para-professionals to provide care and support to this community is enormous, and yet substantial numbers of infected persons remain invisible and under served. HIV/AIDS and older adults was once a seemingly irrelevant subject among both AIDS and aging service providers. Even as HIV infection has moved from the young gay male population to the IV drug-using population to women and children, many of us in the field failed to notice that substantial numbers of older people were becoming infected, getting sick and dying.

Statistics from the Center for Disease Control (CDC) show that nationwide there are now more people over age 50 than under age 20 who are infected with HIV. In New York City, 12 percent of all AIDS cases involve persons over 50 (nationwide, the figure is between 10 and 11 percent). Approximately *one-third* of this number are older gay *women*.

Older Population at Risk

Older adults, gay and straight, women and men, are at risk and need to be targeted for AIDS outreach and preventive and support services. One of the risk factors is that prior to 1985 older Americans (who are the greatest consumers of blood products) were infected through transfusions and mis-diagnosis; their early symptoms (fatigue, loss of appetite, weight loss, swollen lymph glands) were attributed to the aging process.

Physicians and other health care providers were unprepared to look for HIV infection in their older patients, and many in the field are still uncomfortable taking complete sexual histories, especially of persons older than themselves. The myth that older people naturally become sexually inactive has also produced dreadful consequences. Some infected older people went on to infect their partners because they were never provided with information about safe sex. Many older gay men themselves continue to see HIV/AIDS as a younger gay man's problem and ignored or were unable to change life-time sexual practices into safer, life-saving practices.

Little Known

Very little research has been done on this population. We still know very little about how HIV affects the immune system in an older person. (We do know, in general, that older people experience a normative immunological decline.) We do have some clinical evidence that older persons progress to end stage AIDS and die more quickly than younger persons. We do not know whether this phenomenon is attributable to age-related immune dysfunction or simply to delayed diagnosis. We also do not know how current biomedical treatments for HIV interact with the medications most commonly prescribed to older person, e.g., hypertensive and cardiovascular medication. Many persons over 45 are still excluded from HIV/AIDS treatment protocols. Physicians prescribing medication to older HIV-infected persons often have insufficient research to inform their decisions.

Coming Out

Several risk factors make older *women* and gay men especially vulnerable to HIV infection. Since the older gay man who may never have fully come out to family members and employers, or who is married, may have difficulty gaining access to safer sex information and medical and support services. Once infected, the revelation of this man's HIV status may be akin to a second coming out – a process which may include wives, adult children and others in the *their* support system who were not even aware that he was gay.

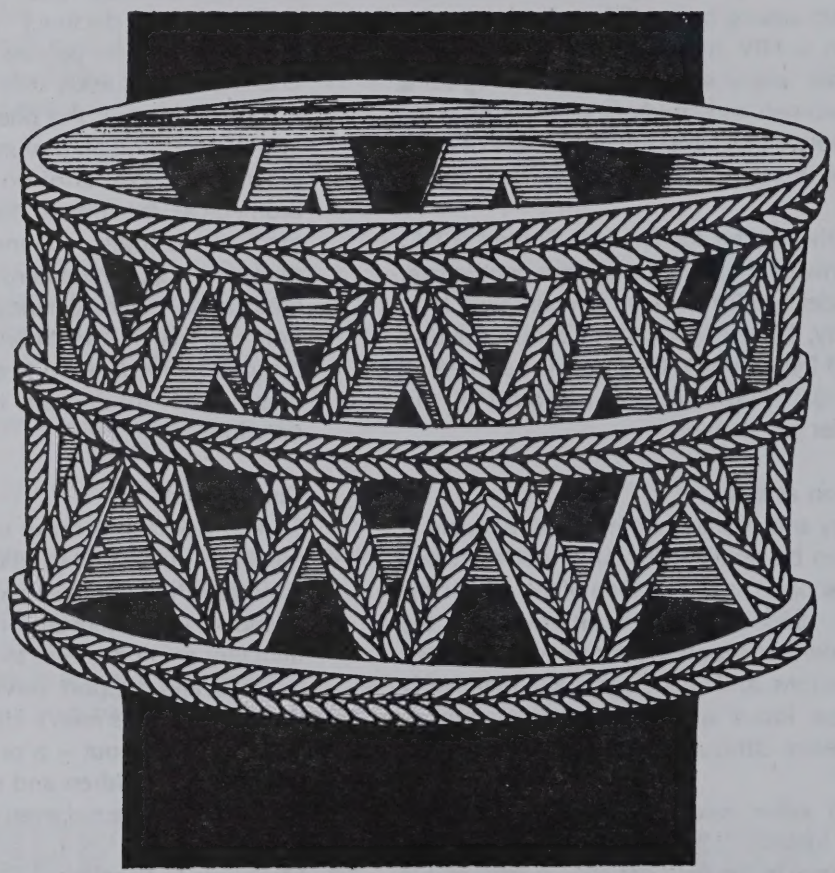
Challenge to Providers

The challenge that lies ahead for AIDS and aging service providers is to develop outreach and prevention and education strategies to serve this difficult population. SAGE (Senior Action in a Gay Environment) in New York City began a model

program for AIDS and elders in 1989. The program provides needs assessments, friendly visiting, support groups for Care givers and for the bereaved, and comprehensive mental health services as well. As part of its ongoing commitment to train professionals in the aging network on issues of gay and lesbian gerontology, SAGE has joined with the Center for the Aging to reach mainstream aging organizations. The HIV/AIDS and Aging Task Force of New York brings professionals from both the AIDS and the aging networks together to bring the issues to the public's attention.

The nation's aging network has enormous resources – private, political and financial – which must be directed to AIDS work for older Americans. The gerontological societies and professional associations need to commit to making the issue a priority at national, state, and local conferences. The complete impact of the epidemic on older adults has yet to be seen, but it is clear that the legitimate concerns of older people and families affected by HIV/AIDS must be appropriately addressed.

Taken in part from **Out World**, Newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, Volume 1 No. 1 Summer 1996



Public Education and Policy

Congress, the Administration and Women's Health 1996: A Year of Qualified Advances

A review of federal policy developments during 1996 in five areas – insurance coverage, reproductive health, prevention, health care for low-income women and research – shows that women made important gains on expanded insurance coverage and more resources for health prevention and research. Women experienced both significant progress and setbacks on reproductive health. And, at a time when the safety net of programs serving low-income populations unraveled, the central health program for poor women was maintained, although poor immigrant and certain disabled women's health services were cut back by changes in welfare law.

1. **Insurance Coverage Expanded.** Women can expect improved insurance coverage as a result of a number of discrete steps taken in the Kennedy-Kassebaum Health Insurance Portability and Accountability Act and several measures guaranteeing minimum benefit levels. These improvements are:

- Portability provided for many workers;
- Pre-existing conditions no longer basis for denial of insurance coverage;
- Pre-existing conditions exclusion improved for victims of domestic violence;
- Increased protection for individuals denied coverage based on genetic information;
- Minimum maternity stay guaranteed;
- Progress toward mental health parity.

2. **Reproductive Health: Progress and Setbacks.** On reproductive health there was a significant progress on Administration-led initiatives to improve dramatically women's access to abortion and contraceptive services, as the FDA took major steps forward toward approval of both RU-486 and the morning after pill.

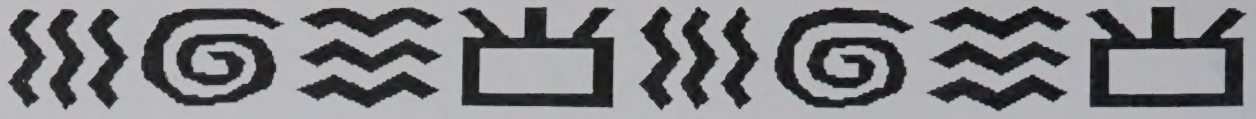
In sharp contrast, there were serious setbacks on congressional-led initiatives affecting reproductive health as women who receive their health insurance from a variety of government programs were denied abortion coverage. Development occurred on the following issues:

- FDA advances on approval of RU-486 (Mifepristone);
- FDA progress on emergency contraception;
- Abortion coverage restricted for women insured under government programs;
- Family planning services associated with domestic family planning saved, but international programs cut severely.

3. **Preventive Health Improved.** Women's preventive health got an important boost especially from FDA regulations designed to reduce teen smoking and from an improved cancer screening program. Key provisions include:

- FDA restrictions on teens' access to cigarettes and advertising targeted to young people;
- Breast and cervical cancer screening improved.

4. **Low-Income Women Escaped Targeted Major Health Setbacks.** Although low-income individuals suffered a tremendous setback when the entitlement to welfare ended, with the attendant risk of harm to



their overall health, health programs serving low-income individuals, particularly Medicaid, for the most part escaped dramatic cutbacks. Medicaid remains an entitlement and federal eligibility guidelines in effect in July, 1996, continue to apply– thus assuring that those most in need will still receive Medicaid. Some Medicaid cuts were enacted, however; and at the same time, there were small increases in other health programs targeted to the poor.

- Medicaid Services cut to legal immigrants already in the country and to legal immigrants arriving after enactment of the welfare bill;
- Medicaid services cut to women disabled because of alcohol or substance abuse;
- Small increases to maternal and child health and social services block grants.

5. **Research: Mixed Record.** The outcome of activity on the research agenda was mixed.

- Breast cancer research increased;
- Osteoporosis research increased;
- Research involving human embryos restricted.

National Women's Law Center
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Washington, DC 20036
(202) 588-5180

Snapshot: Welfare Reform Law Provisions Affecting Reproductive Health

President Clinton signed the new welfare "reform" law into effect on August 22, 1996. It eliminated the 60-year old Aid to Families with Dependent Children (AFDC) program, replacing it with a new block grant cash assistance program to the states, dubbed Temporary Aid to Needy Families (TANF). Among the stated purposes of the legislation is the reduction in the incidence of out-of-wedlock births and the promotion of two-parent families. The following is a preliminary description of some of the provisions that could have a particular impact on women's and adolescents' reproductive health.

Child Exclusion (Family Cap). The final welfare act is silent on child exclusion meaning that states are not mandated – but are now free to enact without federal waiver - so-called family cap provisions that would prohibit women on welfare who have a child from receiving additional benefits when additional children are born. Prior to enactment of federal law, 19 states had obtained waivers from the federal government for child exclusion policies.

Abstinence Education. The new act establishes an abstinence education program under the auspices of the Maternal and Child Health block grant, funded at $50 million annually. This provision, which does not go into effect until January 1998, mandates, among other requirements, teaching that "sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects."

Illegitimacy Ratio/State Rankings. To encourage states to decrease their out-of-wedlock birth rates, the welfare legislation provides for bonuses to states if they reduce the number of out-of-wedlock births (to all women in a given state, not just to teenagers or to women on welfare) during the previous two years. Bonuses will be provided only if the state is able to demonstrate that the number of pregnancy terminations has not increased since fiscal year 1995. Each eligible state will receive $20 million, unless there are fewer than five eligible states, in which case each would receive $25 million. Current data collection efforts by the government or private entities are inadequate to provide this information. The secretary of the Department of Health and Human Services (DHHS) also is required to rank states annually on the percentage of out-of-wedlock births to families on welfare.

Family Planning. Until TANF's enactment, federal law had required states to make family planning services available to welfare recipients, a mandate that was deleted during the creation of TANF. However – although states may not in general fund medical services with their TANF block grant funds – the new law permits the states to spend a portion of those monies on "pre-pregnancy family planning services." (In addition, although some significant

changes were made to Medicaid, the new law specifies that women and children aged 13 to 18 who are or would be eligible for Medicaid coverage based on whether they would have qualified under the former AFDC program would continue to be covered.)

Public Health Benefits for Legal Immigrants. With some limited exceptions, such as emergency care, the new welfare law denies eligibility "for any Federal means-tested public benefit for a period of five years beginning on the date of the immigrant's entry into the United States." If (and this has not received an official interpretation) the Title X family planning program is deemed to constitute a means-tested program, Title X-funded providers, and their clients, particularly in states with high immigrant populations, could be greatly affected.

Unfunded Mandates. TANF also requires the federal government to conduct several activities relating to reproductive health issues – but with no funds attached to carry then out – including:

The secretary of DHHS is required to conduct studies on the effects of state programs on welfare dependency, "illegitimacy," and teenage pregnancy.

The secretary of DHHS is also required to establish and implement a strategy for preventing out-of-wedlock teenage pregnancy prevention programs in place, and to report to Congress by June 1998 on the progress made toward these goals.

The U.S. attorney general is required to establish and implement a program to study the linkage between statutory rape and teenage pregnancy, "particularly by predatory older men," and to educate state and local law officials on the prevention and enforcement of statutory rape law.

Mandatory HIV Testing of Women and Babies: Ineffective at Fighting AIDS

When news media recently reported that AIDS deaths in the United States were decreasing, many reports failed to mention that this encouraging statistic does not apply to women. Women constitute the fastest growing group of people with HIV/AIDS nationwide, comprising 20 percent of all reported cases. AIDS is the third leading cause of death among women 25-44, and the leading cause of death for African American women in the United States.

This alarming increase attests to the ineffectiveness of existing HIV prevention strategies to reach women – and the men whose behavior puts women at risk. These strategies have not reached those women most at risk, have not convinced them to enact life-saving behavioral changes, and have failed to respond to the social, economic and personal stresses that prevent women from taking control over their lives.

As the AIDS epidemic continues, it is fitting that legislators would want to take urgent action. But programs and policies aimed at preventing or slowing the spread of AIDS continue to overlook the complex needs of women, and may actually be detrimental to women's health. The focus of both HIV prevention policy and research has been on reducing perinatal transmission of HIV from woman to fetus – often by imposing mandatory testing of pregnant women and urging AZT treatment for those who test positive. While this does nothing to actually prevent HIV in women, it is nonetheless the core of AIDS prevention programs targeted to women. A bill passed last year in New York requires health officials to inform parents of the results of HIV tests routinely done on infants, without parental consent, and has initiated a storm of controversy raising medical and ethical concerns.

There is much opposition to mandatory testing of pregnant women and their newborns because it violates women's reproductive rights and their rights to informed consent and privacy and will not reduce perinatal HIV transmission or increase access to care and services for women and infants.

A positive HIV test in a newborn does not necessarily mean the child is infected with the virus. Studies show that only 25 percent of newborns who

test positive at birth are actually infected. The remainder simply retain their mothers' antibodies for a short time after birth. A positive test in an infant does, however, mean that the mother is infected. Therefore, testing the newborn constitutes testing the mother, often without her knowledge or consent.

Mandatory testing of pregnant women and newborns creates an artificial conflict between the needs and rights of the pregnant woman and the allegedly competing needs and rights of her fetus. Indeed, defining the fetus as a separate patient to be treated, even in the absence of consent from the woman who carries it, remains a threat to women's reproductive rights and health that cannot be overlooked.

Further, creation of this unfair conflict does not reflect the evidence from research that shows that when women receive accurate and complete information, they will make rational choices for themselves and their future children. Finally, public health measures that target women only when they are pregnant are far less effective than measures that would prevent perinatal transmission of HIV by preventing HIV infection of women in the first place. Indeed, many women's health advocates and physicians argue that mandatory testing may make women afraid to seek medical treatment. There is also the likely possibility that such a policy may coerce women into medical treatment that may actually make more susceptible to the ravages of AIDS.

While the use of AZT monotherapy during pregnancy is applauded as a breakthrough for reducing perinatal transmission, more recent studies have now shown that such therapy carries the risk of cancer in children born to treated mothers. It may also increase the woman's resistance to other, more effective combination therapies, including the new protease inhibitors. HIV counseling and voluntary testing is, however, proving effective.

Studies consistently show that when health care professionals provide pregnant women with thorough counseling, most women choose to be tested and to pursue health care treatment. Under the 1996 reauthorization of the federal Ryan White CARE Act, states will receive funds for programs that require doctors to counsel all pregnant women about HIV testing. If states that adopt voluntary testing programs do not show that they have reduced by half the number of pediatric AIDS cases by the year 2000, then they must implement mandatory testing or lose CARE Act funds.

State legislators must resist this incentive to move toward coercive or mandatory HIV testing and counseling programs. To genuinely help women and children, legislators should target funds to community-based organizations that have a history of successful voluntary HIV testing programs for women, such as women's health clinics. State legislators may have other potential opportunities to address HIV testing and counseling issues for women in the context of Medicaid legislation; these include policies on coverage of testing at anonymous testing sites and testing requirements under managed care systems.

The key to saving babies is to save women. Therefore, state legislators should introduce legislation providing funding for HIV prevention education targeted specifically to women, providing for proven, voluntary counseling and testing programs, and ensuring that these programs have strong linkages to care and services, since testing alone holds no benefit for either a woman or her child.

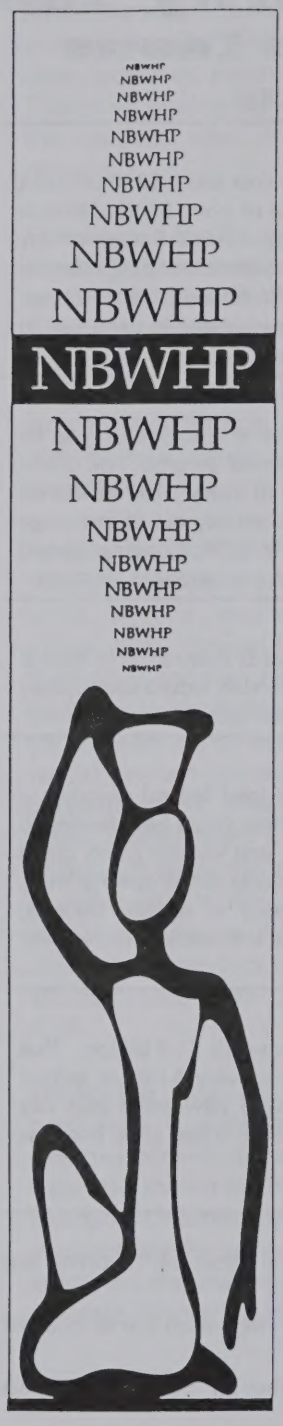
Additional materials available from:
Center for Women Policy Studies
1211 Connecticut Avenue, NW
Washington, D.C. 20036
(202) 872-1770 or Fax (202) 296-8962

Facts and Figures Show Why the Federal Budget is A Woman's Issue

THE FACTS	THE FIGURES
HEALTH CARE Elderly women make up two thirds of all Medicare recipients whose incomes are below the poverty line. At least 75% of nursing home residents are women and more than half of their nursing home costs are paid for by Medicaid. Women and children are more than 85% of all Medicaid recipients. They are the first to feel the cuts in Medicaid and Medicare.	Medicare and Medicaid together cost about $270 billion a year (as of FY96) – about $17 out of every $100 of federal spending. According to the Congressional Budget Office, adding just $18 billion more to current spending (another $1.10 per $100), could cover health care for *everyone*. Instead, both political parties have agreed to deep cuts in Medicaid and Medicare funding.
TAX BREAKS About 75% of all Earned Income Tax Credit claims are filed by women who are working to support their families and earning less than $28,000 per year. This credit assures that workers who earn less than poverty-level wages don't have to pay federal taxes, and those just-above-poverty incomes get a bit of a break.	The IRS sends out about $19 billion in refunds each year for people who qualify for the Earned Income Tax Credit (EITC). That's about $1.20 out of every $100 of federal spending. Cuts in the EITC take money out of low-wage working women's pockets. But in 1996, Congress agreed to reduce the EITC by $17 billion over the next six years.
EDUCATION About 54% of Pell Grant recipients are women – that's about two million women who rely of Pell Grants to help pay for a college education.	Pell Grants costs least than 50¢ out of every $100 of federal spending. But Congressional proposals would save money by taking away about have of these grants.
INCOME SUPPORT About 70% of the families receiving welfare assistance are headed by women who coping alone. Under the 1996 welfare "reform" law, states will turn up the pressure on these vulnerable families. States **may** provide help, or they may not. But **all** states will receive less money from the federal government for cash grants, require work or training, and limit **lifetime** assistance to a total of years or less.	Welfare accounts for just 1% of total federal spending – about $1 out of every $100, welfare could be extended to 3 million more families in need, and welfare grants could be raised to a national standard, closer to the poverty level. Instead, Congress is carving away at welfare benefits, leaving little support for women at vulnerable times in their lives.
JOB TRAINING The JOBS program, created the last time the welfare system was reformed (in 1988), supports education and job training programs for women who are trying to get off welfare. But only a few states started up the JOBS program – most could not afford to provide the state share of funding for the program.	To do Its jobs, the JOBS program needs $4-5 billion. That would mean another 30¢ out of every $100 of federal spending. Of course, people who have good jobs pay taxes...so maybe the 30¢ investment is just good business sense.

These Facts and Figures Add Up.

- ☞ As the lower-paid half of the population, carrying more responsibilities than the other half, women are more vulnerable to the sharp side of living – and more likely to need help.
- ☞ Women who are employed full time still make only 66¢ for every $1 paid to men who are employed full time.
- ☞ Women still do most of the work in the home, including child care, whether or not they are also employed elsewhere and whether or not a spouse is present.
- ☞ And women have to turn a lot of corners – sometimes suddenly: A husband can die or leave home, taking a steady paycheck with him, and the woman has to find a way to support herself and her children.



Bookshelf

WORDS of FIRE

AN ANTHOLOGY OF AFRICAN-AMERICAN FEMINIST THOUGHT
EDITED BY BEVERLY GUY-SHEFTALL

IN THIS PATHBREAKING COLLECTION of articles, Dr. Beverly Guy-Sheftall has taken us from the early 1830s to contemporary times. Only since the seventies have Black women used the term 'feminism'. And yet, it is that concept that she uses to bring into the same frame the ideas and analyzes of Maria Stewart, Sojourner Truth, and Frances W.E. Harper of the early nineteenth century, and the work of women such as the late Audre Lorde, Barbara Smith, and bell hooks, who stand on the threshold of the twenty-first century....She has refused to cut off contemporary African American women from the long line of sisters who have righteously struggled for the liberation of African American women from the dual oppressions of racism and sexism."

- FROM THE EPILOGUE BY JOHNETTA B. COLE, PRESIDENT, SPELMAN COLLEGE

Beverly Guy-Sheftall is the Anna Julia Cooper Professor of English and Women's Studies at Spelman College and the founding director of the Women's Research and Resource Center. She is also one of the founding co-editors of *Sage: A Scholarly Journal on Black Women*. Her previous publications include *Double Stitch: Black Mothers Write About Mothers and Daughters* (co-editor) and *Sturdy Black Bridges: Visions of Black Women in Literature* (co-editor). She lives in Atlanta, Georgia.

Johnnetta B. Cole of the President of Spelman College. Her most recent book is *Conversations: Straight Talk With America's Sister President*. She lives in Atlanta, Georgia.

Available in bookstores everywhere or call W.W. Norton, 1-800-233-4830

Through Loona's Door

A Tammy and Owen Adventure with Carter G. Woodson

♦

written by

TONYA BOLDEN

♦

illustrated by

LUTHER KNOX

Tammy and Owen Bradley are a mischievous brother and sister who one day meet the mysterious Loona, the owner of a small bookshop.

Through a magic door in Loona's store, the children travel back in time to the 1890s where they meet a teenager named Carter, who would grow up to become a historian and known as the Father of Black History.

Facts about
Carter G. Woodson

♦ He is widely known as the Father of Black History.

♦ He wrote 20 books about the history of people of African descent.

♦ He is the chief creator of Negro History week, which began in 1926 and grew up to become Black History Month.

In their encounter with young Carter G. Woodson, Tammy and Owen learn about hope, family, and fortitude and they develop a thirst for knowledge about the people, culture and history they come from. *Ages 7 - 10*

THE CORPORATION FOR CULTURAL LITERACY
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Anything We Love Can Be Saved

The beloved author of *The Color Purple, In Search of Our Mothers' Gardens,* and other bestselling books writes about her life as an activist, in a book rich in the belief that the world is savable, if only we will act.

Speaking from the heart on a wide range of topics – religion and the spirit, writing and language, families and identity, politics and social change – Walker begins with a moving autobiographical essay in which she describes her own spiritual growth and the roots of her activism, including reflections about religion in *The Color Purple.* She goes on to explore many important private and public issues: being a daughter and raising one, dreadlocks, banned books, civil rights, gender communication, and ritual mutilation of children in Ghana. She writes about Zora Neale Hurston and Salman Rushdie and offers advice for Bill Clinton, for Fidel Castro, and for young women growing up. She comments on culture and cats, feminism and race, writing and living. Here are a wise woman's thoughts as she interacts with the world today, and an important portrait of an activist writer's life.

There is always a moment in any kind of struggle when one feels in full bloom. Vivid. Alive. One might be blown to bits in such a moment, and still be at peace....To be such a person or to witness anyone at this moment of transcendent presence is to know that what is human is linked, by a daring compassion, to what is divine. During my years of being close to people engaged in changing the world, I have seen fear turn into courage. Sorrow into joy. Funerals into celebrations. Because whatever the consequences, people standing side by side have expressed who they really are, and that ultimately they believe in the love of the world and each other enough to be that – which is the foundation of activism.

ALICE WALKER

A WRITER'S ACTIVISM

Available in bookstores everywhere or from Random House, Inc. New York website address: http://www.randomhouse.com/

A National Black Women's Health Project Book

Body & Soul

The Black Women's Guide to Physical Health and Emotional Well-Being

A groundbreaking self-help book specifically written to address Black women's health concerns, *Body & Soul* gives voice to the physical, emotional, and spiritual health experiences of Black women today. Sponsored by the National Black Women's Health Project and drawing on the expertise of Black female scientists, academics, health care practitioners, and writers, it features the first-person stories of more than sixty women from across the country. With more than 100 illustrations and photographs, *Body & Soul* is organized into six sections:

* Our Bodies
* Our Reproductive Health
* Our Emotional Well-Being
* Loving
* Health Care
* Keeping Safe in a Hostile World.

"Good health is about intuition. When faced with health challenges, we must collect all the information, talk to all the doctors and then go inside ourselves and take direction from our inner voices. We have to believe in ourselves and believe in our ability to make the right decision that will lead to healing."

–Linda Villarosa, from the Introduction

Available at bookstores everywhere. Published by HarperCollins Publishers, New York Call 1-800-331-3761

Linda Villarosa, Editor

Foreword by Angela Davis and June Jordan

ESTROGEN: THE NATURAL WAY

Over 250 Easy and Delicious Recipes for Menopause

by Nina Shandler

Women need estrogen. But how much estrogen do they need? And for how long? Most women over forty won't produce enough to prevent or minimize the short-term symptoms of menopause - hot flashes, night sweats, fuzzy thinking, a diminished libido - or to help safeguard their hearts and bones in the long term.

For more than 40 million menopausal women in America today, the decision of whether to undertake traditional hormone replacement therapy which restores estrogen through a pill or patch can be a difficult and often a very frightening choice. Although HRT can reverse the symptoms of menopause, it also appears to require long-term use to secure long-term benefits. And with that long use seems to come an increased risk of breast cancer. Experts believe it could be another ten years before we know the real impact of these hormones on women's health. So, the real question at hand is?

Can women replenish their diminishing estrogen supplies with a potentially cancer-protective form of estrogen rather than a potentially cancer-promoting form? **The simple answer to this question is *Yes.* Potentially cancer-protective estrogen can be found in food.**

When Nina Shandler reached menopause, she was determined to find a better way. She shares with us in her new book ***Estrogen: The Natural Way*** her results after researching and finding that it is indeed possible to reverse the symptoms of menopause through diet, while at the same time reaping the benefits to the heart and bones that come with HRT. Much to her surprise, the evidence was everywhere, from scientific publications like the Journal of the American Medical Association and the New England Journal of Medicine to Time, Good Housekeeping, The New York Times, and Prevention.

What Nina learned will come as news to most women, and very good news at that: Estrogen occurs naturally in certain foods, primarily soy and flaxseed, in a form known as plant estrogens. Soy products and flaxseed are widely available in practically every supermarket or health food store in America. In her book, Nina explains a simple system for estrogen consumption. She has developed a personal program that any woman can adapt to suit her own food preference. Part eating program, part cookbook, Estrogen: The Natural Way presents a powerful way for women to undergo a gentle yet effective version of estrogen replacement therapy.

Here's to your culinary delight and well being; we have printed in our Nutrition section a few of the recipes that the sisters at the NBWHP found to be of a wide variety and quite tasty.

Villard Books, New York
(can be purchased at your local bookstore)

A Celebration of Activism

The National Black Women's Health Project (NBWHP) and Alice Walker presented ***A Celebration of Activism,*** on April 28th in Washington, D.C. Included were readings from Alice Walker's newest book, ***Anything We Love Can Be Saved.*** The book is a collection of essays on activism. They include women's health, theology, female genital mutilation, censorship, dreadlocks, Indian rights, Cuba, Zora Neale Hurston, Sweet Honey in the Rock, Winnie Mandela, Audre Lorde and the Million Man March. This celebration introduced NBWHP and its programming to metropolitan Washington community, including its Drug Prevention Program designed specifically for African American women at Historically Black Colleges And Universities (HBCUs).

The event, which also honored Alice Walker and celebrated the philosophy of activism, consisted of the readings by special guests such as Writer and NBWHP Board member Angela Davis, Congressional Black Caucus Chairwoman Maxine Waters, Writers Sonja Sanchez and Nikky Finney, Performing Artists Jasmine Guy and S. Epatha Merkenson, plus Wilma Mankiller and Helen Rodriquez-Trias. Sweet Honey in the Rock closed the program.

We are all still on a natural high from the April 28th activities! First, the meeting with the HBCU representatives and four major Sororities, Links and NAFEO, was a great success and very productive. Each participant has committed to working in partnership with NBWHP on the HBCU initiative and agreed to the formalization of an Alliance to, among other things, seek out federal grants to support this and other initiatives with NBWHP.

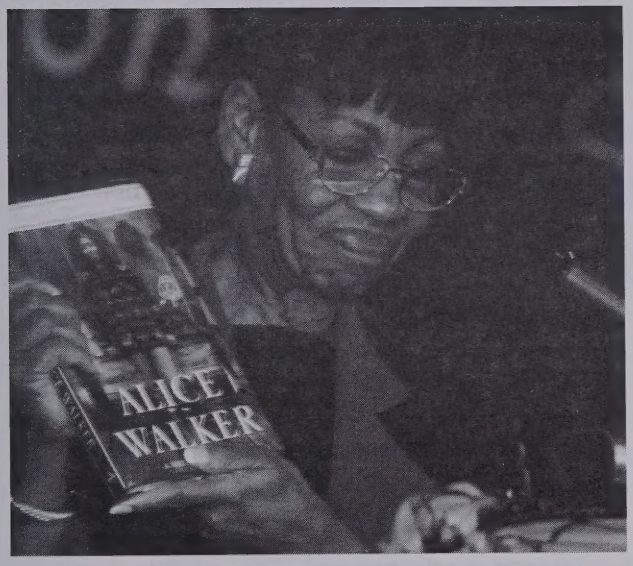
Secondly, the Alice Walker event celebrating activism and the official announcement of the move of the national office to the Nation's Capitol was a wondrous event.

There are so many people to thank for our success. Seven board members were able to attend the April 28 activities. I especially want to thank Angela for moving mountains to change her class schedule to be our celebrity reader and Byllye and Nzinga for their tireless efforts to make this THE event of the year in DC. Also the board members who participated in the HBCU meeting and Event activities. A special thanks to the board members who purchased tickets, even when they could not attend. And last, but not least, the staff and volunteers who pitched in and did whatever needed doing.

Of course, Rusty Jackson Productions did an outstanding job with such short notice. So many attendees sent notes and told us what a wonderful, enriching, powerful and moving event it was and that we had raised the standard for fundraising events in DC!

At the end of 1995, NBWHP relocated its headquarters to the District. The organization is positioning itself to deal with the political and financial realities of our society. We know that our health is aggravated by the extreme stresses created by socio-economic factors such as poverty, racism, sexism, homophobia, fragmented health and social service delivery, and the crippling impact of violence and drug abuse on our communities. It is this reality that the unblurred vision of the National Black Women's Health Project insists we all recognize and change.

Review taken in part from **The Prince George's County Times**, vol. 2 No. 50, May 16 - 22, 1997


ALICE
WALKER

Celebration of Activism"

Chapter Corner

The City of Sisterly Love Proudly Presents **Philadelphia's Black Women's Health Project**

As we prepare for our transition into the next millennium Black women should now, more than ever, take inventory of their physical, mental and spiritual health needs. For many Black women, the pressure of just surviving and making choices based on limited resources leaves little room for realizing the critical role that good health plays in one's life. Fannie Lou Hamers' cry. "We're sick and tired of being sick and tired" epitomizes the frustration we feel at not being able to attain the physical, mental and spiritual well-being that we want for ourselves and our families.

In 1983, a group of local women answered the call for organized leadership around Black women's health issues by establishing the Philadelphia Black Women's Health Project (PBWHP). Guided by our mission of defining, promoting and maintaining the physical, mental and spiritual well-being of Black women. The PBWHP services include health education, advocacy and self-help programs. However, there is still more work to be done. Black women continue to represent the poorest health status of all Americans.

The healthy survival of future Black Generations depend on the health *survival* of the Black community. Only by collaborative efforts can Black women present the powerful force necessary to reverse pervasive and negative health care trends.

In the Spirit of Love and Sisterhood.

Brita Hudson-Smith
Executive Director

P.R.I.M.E.
The PBWHP's P.R.I.M.E. and P.R.I.M.E. West/Healthy Start (Partners in the Reduction of Infant Mortality Efforts), provides outreach, health and parenting education, self-help programs, advocacy and support services to pregnant and parenting women and their families in North and West Philadelphia to reduce the incidence of infant mortality.

Do You and Your Family Need A Connection
The PBWHP's KidConnection provides education, referrals, and health care services to families with children ages 0-6, in North Philadelphia. The program offers workshops on topics such as lead poisoning, nutrition, respiratory diseases, and child safety.

KidConnection has developed successful partnerships with neighboring schools and community agencies. The program facilitated a five week Junior Doctor/Nurse Workshop series for children of the Paul Lawrence Dunbar Elementary School during the summer of 1996 and has provided a number of workshops to neighborhood residents as the R.W. Brown Community Center. KidConnection also publishes a quarterly newsletter. *For more information contact Juliana Taylor, KidConnection coordinator at (215) 232-1115.*

Sisters in Touch
African American Breast Cancer Survivors Group. *Sisters in Touch* is comprised of African American women breast cancer survivors who are spiritual, committed and willing to fellowship.

Sisters in Touch, began as an outgrowth of the PBWHP's *Sisters for Sisters: Surviving The Challenge of Breast Cancer* program. *Sisters in Touch* provides participants with educational information and emotional support during the different phases of survivorship. Educational topics include: Nurturing the Body, Nutrition For Survivors, Psychological Exercise, Image Enhancement, and Family Support.

Sisters For Sisters was the first African American education program in Philadelphia to focus on the severity and pervasiveness of breast cancer survivors who are spiritual, committed and willing to fellowship.

As an inspiration to other women, the Project with the support of the Breast Health Institute, launched a survivors *Portrait Project*. Drawing on their own strengths, 21 *Portrait Women* gave their own personal message to other women under each of their portraits. The poster was on display at the *Race For the Cure* held on Mother's Day, May 12, 1996.

The excitement and energy was so positive it has stimulated the survivors to form an alliance with each other for fellowship, networking and support. For more information on *Sisters in Touch contact Janet Cash, 1231 North Broad Street, Suite #3C, Philadelphia, PA 19122, (215) 232-115, Fax (215) 232-2847*

The Sisters at the National Black Women Health Project National Office salute The Philadelphia Black Women's Health Project for their collaborative efforts in becoming the Vanguard of the Black women's health movement in Philadelphia.

Introduce Yourselves to the Sisterhood...

We want to be sure we know each and every one of our sisters in self help. You can help!! Please fill out and return your self help group registry so we can stay connected as the sisterhood of NBWHP continues to grow. Mail to our National Office. NBWHP, 1211 Connecticut Ave., Suite 310, Washington, D.C. 20036

Register now!!

SELF HELP GROUP REGISTRY

Name of Group (*optional*)_____

Location & Frequency of Meetings_____Number of participants_____

Name of Contact Person(s)_____

Address_____

City_____ State_____ Zip Code_____

Phone_____Fax_____ E-mail_____

How long has your group been meeting?_____ months/years

Is your group based at your: work site__ local school__ church__
neighhborhood or community_ Other__

What are some of the primary health issues or topics discussed by your group recently?_____

_____

_____

Mail to:
National Black Women's Health Project

Speaking Out on Health: Reflections of Midlife and Older Members of the National Black Women's Health Project

In February 1995, a new Center was established to address the concerns of mid life and older women as they planned for their later years. From the beginning, the NBWHP was a partner in the new endeavor, providing valuable suggestions about projects the Center should tackle. One of those projects involved surveying and holding focus groups with NBWHP members to identify effective practices and needed changes in the current health care system. We hope you will enjoy reading this article about NBWHP members' opinions and experience in seeking and receiving health care.

Early in 1996, the NBWHP selected members affiliated with its California State Office to participate in a collaborative project with the National Policy and Resource Center on Women and Aging which had been established under a grant from the Administration on Aging the year before. Focus groups were held and surveys conducted to learn about the experience of members in finding and using health care. The following report summarizes the major findings of this study.

In the two focus groups, women described their health problems, their needs, and their experiences with the health care delivery system; they also completed a health survey. The survey and the group discussions raised six types of questions:

(1) What health problems are you experiencing?
(2) What do you do to keep healthy?
(3) Who is your health care provider, and what *do* you like and what do you *not* like about your interaction with him/her?
(4) What are your health care needs, and what priorities do you and your communities set among them?
(5) What kind of insurance do you have, and are you satisfied with your coverage?
(6) What changes would you like to see in the health care delivery system?

Fourteen women participated. Their age ranged from 52 to 82 years, and the average age was 60 . Most of them were high school graduates, and five women had attended or graduated from college, but six of the 14 women had only an eighth grade education. All described themselves as African American. Three of the women lived with a spouse, and six had adult children and/or grandchildren living with them. All but four of the women had worked outside the home–an average of 22 years each of paid work–but only half had ever had employer sponsored health insurance, and even fewer had ever received sick leave (43%) or vacation (35%). Four of the women were currently retired, and five were working either full-time or part-time. Most of the women lived in a rented apartment (71%).

The majority of the women reported fair or poor health. Half of the women reported arthritis. High blood pressure and diabetes were each mentioned by four women. Anemia, heart disease, digestive problems and depression were listed less frequently. Interestingly, eight women–more than half–reported current medical symptoms that they thought were related to their prior or current jobs.

We asked these older women, "Who do you think is responsible for your health?" These women felt responsible for both illness and health. One said: "As women, we bring a lot of health problems on ourselves, a result of not working from the inside out. Truth and good health comes from how we feel about ourselves." They were quite concerned about the old cultural belief that you should follow a doctor's advice without raising questions. They advised, "don't do everything the doctor tells you to do." The women in the group do not accept a lot of the statistics published; they said, "the surveyors

never ask any of *us*!" Another woman said, "We do not have people who empathize with our plight." There was a strong sense that individuals have to be advocates for their own health.

The women in the study describe a wide variety of illness prevention activities, including exercise, getting check-ups, taking medicines, eating right and getting enough rest. All had a recent mammogram.

But the most important aspect of activities these women undertake to safeguard their health is the emphasis they place on spiritual health. "Peace of mind," says one woman, "helps to keep you healthy." They pray, meditate, practice Yoga, and go to church. As one woman said, "I'm not an overly religious person, but I find a sense of community and a sense that I'm not alone. This helps to take away stress." Friendships and relationships with family are important. Another woman keeps young people in her life, sits down with them and "listens to their puppy love stories." Yet another woman said that she has learned that "if you tell too many people, you reinforce the disease; you have to put more energy on the healthy aspect of yourself."

The women in the focus groups felt that taking health into their own hands–deciding for themselves what is right rather than accepting without question physicians' recommendations or medications–is a positive step. As one woman said, "We should live in acceptance if it's out of our control. But if it's somewhat in our control...."

Women expressed many concerns about their future health. Some of their worry centered around diseases for which they might be at risk: arthritis, vision problems, HIV. They worry that their grandparenting responsibilities may leave them with too little time or energy to take good care of themselves.

They wonder about the aging process itself: "Is it happening naturally, or am I doing something wrong? Which body parts carry the most stress? Am I aware of the overload?" They want especially to be able to stop taking so much medication, stop overeating and eating the wrong things, and stop worrying about their grandchildren. They want to be able to afford health care when they need it, and they don't want to have to go into a nursing home.

About health care providers.... Half of the women would prefer to see a practitioner who is the same age or older; most of the rest had no preference about age. More than half of the women had no concerns about the gender of the practitioner; only four women preferred a female doctor.

Twelve out of fourteen women have a regular doctor. For the majority, this physician is a general practitioner, a family practice doctor, or an internist. Although gynecologists provide much primary care, only one woman listed a gynecologist as a 'regular doctor,' and none relied primarily on any other type of specialist.

Provider attitudes Focus group members were asked a number of questions about the attitudes of current providers and the quality of health care they provide. Most of the women (71%) thought that their doctors acted concerned, asked them how they were feeling, and listened to them. Fewer (57%) thought that their doctors explained tests to their satisfaction, respected their health beliefs, or were interested in their safety. Only one woman reported being asked the difficult question about risk factors for HIV exposure, but because of societal stereotypes about promiscuity among Black women, many said they would rather *not* be asked.

Satisfaction with health services Seven of the 14 women reported being very satisfied with their present health care services, six were somewhat satisfied, and only one was not satisfied at all.

Access to care Twelve of 14 women said they were able to arrange appointments whenever they needed the attention of a health care provider. Half saw a private doctor most of the time, and more than a quarter used a hospital clinic.

Sources of medical advice Who would these women turn to as the first source of medical advice? Almost half would contact a general practitioner first

for health information. Other women would turn first to a friend, a specialist, a nurse, or an alternative healer.

Women also ranked the services they wanted in the order of importance on a scale of one to five, from the least important ("1") to the most important ("5"). These services are listed below, starting with those ranked most important.

In general, the women in these two focus groups would like to see present services expanded, and are very concerned about their future access to health care. Eight of the women would like to see Medicare expand its program, although only four are completely dependent on Medicare insurance. All are concerned about the cost of medical care, and half would have to see the doctor less often if co-payments were to be increased. Only five of the women were very satisfied with their health insurance coverage; four were somewhat satisfied, and three were not satisfied at all.

We asked, "if you were speaking with the President tonight about health issues, what would you ask him to do?" The women had excellent suggestions:

- √ Continue to fight for a health plan for this country, especially for women and senior citizens.
- √ Provide more transportation for the handicapped and seniors.
- √ Give quality care in the health care package.
- √ See what can be adopted from other countries like England and Canada where care is free.
- √ Develop more volunteer programs, with incentives for young and old.
- √ Provide social centers and housing for seniors, and investigate rest homes and nursing homes where people are being neglected and mistreated.
- √ Put more money into home health care instead of nursing homes. In the long run it is less expensive and makes more jobs. Provide more funding for homemaker chores (in-home support services). Provide affordable healthy living.
- √ Spend more money on preventive care and on Medicare. Treatment under Medicare should match that of richer patients.
- √ Fix the problems with insurance coverage rules and regulations (The little hardships that slip into the system).
- √ Continue to fund projects like the National Black Women's Health Project, Hispanic women, and Family Recovery projects that promote community healing and let the citizens get in touch with their cultural heritage.
- √ Provide funds to train young people, and incentive programs that pay for school and encourage graduates to go back into the community to work. Continue to fund youth projects, with more staffing, and make the success stories more visible. Youth projects need to be continued and expanded.
- √ Support groups that promote healthy eating habits and regular exercise.

For more information, contact the National Black Women's Health Project, 1211 Connecticut Avenue, NW, Suite 310, Washington, D.C. 20036, 202-835-0117 and the National Policy and Resource Center on Women and Aging, Heller Graduate School, MS-035, Brandeis University, Waltham, MA 02254-9110, 1-800-929-1995 or 617-736-3866.

African American Women Respond to Health Survey...

How important is health to you?
The women in the focus groups said that yes, health *is* important to them–they talk about it all the time: to sisters, friends, and daughters, on the bus, on the phone, in stores, in regular conversation. But health is most important, they said, when they are in pain, or when there is a crisis.

How important is health to your community?
Although the women agreed that health is a very important issue, they thought it wasn't taken seriously enough by their communities. Food and shelter, by necessity, receive more attention, so some health services are lacking, or located too far away. In particular, there is an insensitivity to Black women with chronic pain.

Health status

Do Black women have special health concerns, and if so, what are they?
The women in the focus group listed many concerns:
Things are not told to Black women concerning health issues, and too many doctors are not listening to their patients. Doctors are biased towards groups of people who can afford health expenses and insurance (money talks).

We have too much of: stress, fibroids, diabetes, cancer, high blood pressure, arthritis, and children being raised by grandmothers, which causes stress and tension and leads to high blood pressure, heart disease and fatigue.

We have too much dependence on Medicare, and too many fixed budgets; we have too little money for preventive care.

Physicians give us too many psychiatric referrals when we have health problems, too many operations like hysterectomies, and too many drugs for pain.

Transportation was a special problem: "Older people need transportation to get to medical appointments. What's available is stressful, because seniors have to wait for 75 other people to get finished before they can go home. Cab fare is too expensive."

What do you do to keep healthy?–prevention activities?
One woman described how she "just now found the right medication. I fight for my health care. I ask a lot of questions. If they get angry, I get angry. I take medication daily, exercise, and try to stop worrying."

"I look at my mother's and grandmother's problems and wonder if their illnesses will happen to me."

"My parents and my grandparents may have eaten better–more fresh fruits and vegetables. They didn't pay attention to cholesterol, but the diet may have been more nutritious in my mother's generation."

Women work on their health on a daily basis: "I stopped overeating, began walking more, and made an effort to take my medication as directed instead of stopping when I felt better."

Concerns for the future–what do women want?
"I want to be the oldest, healthiest person around....No more arthritis, high blood pressure or anything else!"

"We want to teach our children and grandchildren not to neglect their health!"

"I want to maintain the health I have now!"

What are your health care needs, and what priorities do you set among them?
Along with these health care priorities, women mentioned the need for affordable social activities for seniors.

What changes would you like to see in the health care delivery system?
"How can a rich person tell a poor person how to live?"

"Please find out the needs of the majority of our citizens. Send out a national survey. Thank you."

HEALTH CARE CHARACTERISTIC	MEAN SCORE
Group exercise is offered.	4.7
Prescription drugs are covered by insurance.	4.6
Free mammography is provided.	4.4
Provider explains tests/therapies clearly.	4.4
Vision exams and eyeglasses are covered by insurance.	4.3
Health care explanations are given in understandable language.	4.3
The physician provides adequate time for talking.	4.2
Home nursing is covered by insurance.	4.1
Nutritional information is available.	4.1
Links are provided to community services.	4.1
Hearing testing and hearing aids are covered by insurance.	3.9
Privacy is respected.	3.9
Screening for bone loss is provided.	3.8
Help is available to find the right MD.	3.6
Nursing home is covered by insurance.	3.6

HEALTH SURVEY: AFTERTHOUGHTS

As a component of the *Research and Policy Analysis Activities* for the center's cooperative agreement with the Administration on Aging, the National Black Women's Health Project agreed to conduct focus groups to gather information about women's experiences in searching for and receiving health care.

As a result of the focus group sessions conducted, information was gathered that provided a preview of the variety of issues and concerns that older African American women face.

The survey did not produce any new findings but coincided and reinforced the existing research on the status of the older African American women's health care situation. These findings are that:

- Older African American women are all not the same, they are not a monolithic group that can be stereotyped into one category. The survey demonstrated that they vary in their marital status, levels of education attained, economic status, types of work experiences, and religious affiliation. All of these have a direct correlation to health seeking behavior that positively or negatively impacts their health status.
- The major chronic health diseases for older African American women continue to be heart disease, hypertension, diabetes, cancer, arthritis, stroke, liver and kidney problems, and fibroid tumors that result in hysterectomies.
- Access to receiving health care is often hampered by social and economic situations that take precedence over receiving preventative or routine health care services.
- Health has been and is still an important issue for African-American women.

Beyond these four broad known facts the survey did not delve into some of the major issues that impact upon and have an affect on the health, care giving and financial needs of older African American women. The survey instrument was designed without taking into consideration the audience that was targeted. By attempting to administer a universal questionnaire to a specific population i.e., older African American women, an opportunity to capture critical information on this subgroup, was missed. The survey instrument was not framed to elicit information of the types of activities needed in terms of prevention/maintenance educational programs or public policy actions that need to be addressed to improve upon the condition of older African-American women. To impact the health seeking behavior of older African American women, information needs to be gathered on pertinent issues important to them. These issues include life events that cause undue stress and increased illnesses. Issues such as:

- older African American women as grandparents having the responsibility of parenting their grandchildren without any legal assistance or financial support,
- dealing with adult children and other family members that are suffering with AIDS,
- adult children returning to their home because of loss of jobs, divorce, or some other unexpected traumatic event or life experience,
- social isolation and depression due to being fearful of leaving their homes because of drugs, crime, and violence in the community,
- forced retirement with no way of generating income to remain independent and only having social security and possibly a small pension to rely upon,
- having to care for a sick spouse or other family member when their health is also failing,
- decreased functional ability because of uncorrected sensory impairments, and not being able to purchase the adaptive equipment or aid (i.e. eyeglasses, hearing aids, cane, or walker) because it is not covered by the insurance and there are not enough personal financial resources to cover the costs,
- having to choose between buying food to eat, paying a utility bill to remain warm or cool in the home, or purchasing the prescribed medication so

that they can remedy the health ailment,
• being house rich but cash poor, and not qualifying for free or low fee health and social services,
• overwhelming responsibility of being a part of the sandwich generation, in that they are responsible for the caretaking needs of children, and their own parents,
• premature institutionalization because there is no one to assist with activities of daily living (ADL's – bathing , dressing, cooking, etc.)
• overwhelming Care Giving responsibilities and not being aware of community resources available to assist.

All of these barriers, issues, and concerns, are magnified by the fact that older African American have been stereotyped with the misconception of having triple jeopardy syndrome of being black, female, and old which translates into racism, sexism, and ageism. This label of triple jeopardy has an impact on the way older African American women seek and receive health care which is reinforced with the fact that:

• Access to receiving health care services is often hampered by the confusing health system itself as it relates to copayment and reimbursement with Medicare and Medicaid issues and forced managed care by HMOs.
• There is just cause for some older women to be fearful of trusting the physician because of past bad experiences such as the Tuskegee experiment with syphilis.
• Older African American are often told by their physicians they need examinations or surgeries without explanations of the procedure or why it is necessary.
• Older African American women are often over medicated or prescribed medications before trying less intrusive medical/health therapies.
• Physicians tend to be less patient and sensitive to the needs of older African American women and tend to discount their belief in faith healing, herbal remedies, and home remedies despite the fact that positive results are achieved as a result of not following traditional medicine.

To move beyond the identification of health diseases that pit the older African American woman against the older white population, with increasing dismal morbidity incidences and mortality rates, there needs to be research conducted on life satisfaction and life events. The indicators on their health seeking behavior should be the basis for the development of prevention and self-help programs. Programs should not be a "cookie cutter one size fits all program" but one that is flexible enough to incorporate the major health and interrelated financial, social and governmental issues for the diverse life experiences among this group of women.

The National Black Women's Health Project has garnered experience and data from African American women nationwide to be the public policy voice concerning African American women's health issues. Additionally, the national scope of the NBWHP allows the organization to feed critical information to its local chapters that will enable them to develop, implement, and evaluate self-help/ health promotion programs that focus on the above mentioned issues.

NBWHP will work in conjunction with the National Policy and Resource Center On Women and Aging and all of the collaborating partners, to issue legislative briefs, develop fact sheets, implement programs, and evaluate activities. The evaluation protocol will focus on process or formative evaluation and will be guided by the input of women who can provide critical information for developing programs aimed at improving the quality of their life.

Older African American Women, Health and Poverty

According to the Older Women's League (OWL), one in four older women today lives in or near poverty even with Social Security benefits. The situation is even worse for African American women. In 1993, 31% of African American women age 65 and older lived in poverty. In addition, 88% of African American women had Social Security income compared to 93% of white women, and only 25% of African American women had income from assets compared to 71% of white women. In 1993, the median income for African American women age 65 and older was $6,582 compared to $8,778 for white women.

The income wage gap widens with age. For example, women age 55 to 64 who were employed full-time were paid just 66% of what men the same age were paid ($398 a week for women, $603 a week for men) compared to women age 24 to 34, who were paid 83% of what men the same age were paid ($397 per week for women, $479 for men).

According to Dr. Johnetta Marshall, President of OWL, "the path to poverty for millions of women begins with their first day of work in low-wage, no benefit jobs. Women grow poorer as they grow older because their low wage jobs are usually combined with inadequate retirement systems." She went on to say in her Mothers' Day Report, "women are the traditional family care givers and that responsibility is still driving the way they work. They are more likely than men to stay at home to care for their children and sick or elderly relatives." This is certainly true for African American women, who take care of the children, grandchildren and even great-grandchildren if their parents are claimed by the criminal justice system or AIDS, for example.

"The current retirement system punishes these women instead of supporting them or rewarding them. Women often do not realize what impact this will have on their income later in life. Even when women understand the consequences, they too frequently have no other choice," said Dr. Marshall.

Older women, particularly African American women, are usually found in traditionally female occupations (administrative support, sales, and services), according to the American Association of Retired Persons (AARP). They may want to work full- time but cannot find full-time permanent work. Again, it is because they disproportionately perform the child-rearing and family care giving, many prefer the flexibility or shorter hours contingency work (part-time, temporaries, on call, leased workers) offers. Black women (26%) age 45 and older are far more likely than white women (6%) to work for temporary agencies. Many women – particularly women of color – lose out on Social Security protection because they hold "invisible" contingent jobs in peoples' homes, such as house cleaners, nannies, and home health care aides. These jobs are often less than full-time with any one employer; therefore, they are most susceptible to evasion from or falling below the threshold for the requirement to withhold social Security payroll taxes.

In*Women's Health*, the authors (who evaluated the Commonwealth Fund Survey of Women's Health in 1993) noted that African American women are more likely than white women to be living in poverty (33% v. 12%) and to have less than 12 years of education (24% v. 14%). Less education often means less care, African American women with the least formal education are at substantially greater risks of not getting timely clinical preventative services. For example, African American women who did not graduate from high school were twice as likely not to have received a clinical breast exam in the last year as white women.

African American women experience more health care access problems and are more likely than white women to express frustration about finding care. Low income, less educated, and minority older women appear to be the most vulnerable to both chronic conditions and disabilities.

The authors, also, noted that significant proportions of mid life women between the ages of 40 and 65 experience serious health problems and engage in non-healthy behaviors. Fifteen percent of mid life women rated their health status as fair or poor, and 30% had been diagnosed with one or more chronic illnesses. The most frequent occurring problems were arthritis (31%), high blood pressure (25%), and depression or anxiety disorder (17%). Despite the known hazards of smoking, 23% of mid life women smoke cigarettes. Nearly one-third do not exercise. Only 24% of mid-life women were reported as using hormone replacement therapies to reduce cardiovascular disease and osteoporosis.

Women age 65 to 85 experience comparatively high rates of chronic diseases, disability, and depression, and show a lack of awareness about preventive health measures. Half of the older women surveyed reported having two or more chronic diseases, and 24% reported having three or more chronic diseases. Again the most prevalent were arthritis, hypertension, heart disease, depression or anxiety, and cancer, which was not as prevalent for women in mid life.

Between the ages of 35 and 74, the death rate from heart attack in African American women is twice that in white women and three times that in women of other races, according to the Association of Black Cardiologists' position paper on cardiovascular diseases in African American women. African Americans have a 40% higher age-adjusted prevalence of hypertension than whites and Mexican-Americans. The onset of hypertension is earlier and it is more severe in Blacks resulting in a 1.8 - fold greater rate of fatal stroke, a 1.5 - fold greater rate of heart disease deaths, and a fold greater rate of end-stage kidney disease compared with whites. Between the ages of 30 and 69, the prevalence of hypertension is greater, and the mean systolic and diastolic blood pressures are higher in African American women than that in white and Mexican-American women. In the 60 to 69 age group, 80% of African American versus 55% of white women and 60% of Mexican-American women have hypertension.

Fifty-one percent of African American women aged 20 and above have undesirably high serum and cholesterol of greater than 200mg/dl: 19% have levels above 240mg/dl. Lp(a) lipoprotein levels, which correlate directly with an increased independent risk for coronary heart disease, are two-fold higher in African American women than in white women.

Eight percent of Black women have diabetes compared with an average of 3% for all other women. The risk of an initial heart attack is more than doubled in women with diabetes. Twenty percent of African American women over the age of 18 smoke. Smoking and the concurrent use of oral contraceptives significantly increase the risk of a stroke.

The position paper noted that lower socio-economic and educational levels tend to correlate with a higher likelihood of a sedentary lifestyle. Physical inactivity is associated with and increased relative risk of coronary heart disease. Fifty percent of African American women are 20% or more above desirable weight. Being more than 30% overweight is an independent risk factor for cardiovascular diseases.

The Morehouse School of Medicine's Chief of Cardiology and Vice President of the Association of Black Cardiologists, Elizabeth O. Ofili, M.D., presented a paper on the problem of heart disease and stroke in African American women. Her recommended solutions include the following:

- Community educating and prevention programs that are culturally appropriate regarding food choices, exercise, and weight management – particularly when targeted to churches or other community gathering places.
- Black community groups are crucial to mobilizing members and others in the community to participate in prevention and treatment programs.
- Increased enrollment of ethnic minority medical students, nursing, and other health care professionals who will practice in inner city, rural, and other underserved communities.
- Increased funding for cardiovascular research in African American women of diverse socio-economic

backgrounds.

♦ Community effort and mobilization to encourage participation in clinical research.

According to the American Psychological Association's *Research Agenda for Psychosocial and Behavioral Factors in Women's Health*, in order to have an impact on women's risk of chronic disease, there must be intervention in the four prominent health behaviors influencing chronic disease: alcohol and other substance abuse, cigarette smoking, dietary patterns, and physical activity patterns. In addition, it is important to note that six of the ten leading causes of death are behaviorally based: violence, smoking, AIDS, accidents, substance abuse, and diet.

The statistics are daunting. However by empowering Black women through education, we can make a difference in the health of not only ourselves but our families and communities.

Lori Valencia Greene
American Psychological Association

Older Women's Health Care Needs

Mid-life and older women have unique health care needs which–together with their lower incomes–must be considered when assessing the advantages and disadvantages of managed care:

♀ Women live longer than men–seven years longer on average– and have a higher rate of chronic conditions such as osteoporosis, arthritis, diabetes, multiple sclerosis, lupus, urinary incontinence, thyroid problems, and cancers affecting the reproductive organs or thyroid.

♀ Access to gender-specific preventive and screening services--including mammography, clinical breast exams, Pap smears, bone scans, and blood pressure screening–is crucial to ensuring women's health as they age.

♀ Because older women often have a complex array of health problems and conditions, coordination and continuity of care is particularly important.

♀ By the time a woman is 65 years old, she is almost twice as likely as her male counterpart to be living in poverty–making financial barriers to health care a particular problem for older women.

Opportunities in Managed Care

♀ By providing preventive and screening services to mid-life and older women with minimal cost-sharing requirements, managed care can remove some of financial barriers to services that exist in a fee-for-service system.

♀ Mid-life and older women enrolled in HMO plans receive more preventive, screening, and primary care services than those with fee-for-service insurance– and women ages 50 and over with HMO coverage are more likely to receive Pap smears, clinical breast exams, and mammograms.

♀ Managed care has the potential to improve coordination of health care services–a feature that is particularly important for older women with chronic conditions and those who require a complex array of services from multiple sources.

Risks in Managed Care

♀ Managed care typically limits access to the providers included in the plan network, restricting consumer choice and leading to disruption of care when mid-life and older women must change health plans–because they change jobs, their employer switches plans, or their spouses' circumstances

change.

- ♀ Managed care contains financial incentives which can encourage providers to deny services and to forego recommendations to specialists-resulting in substandard care for mid-life and older women.

- ♀ The gatekeeping dimension of HMOs that requires patients to see a primary care physician poses a special risk for older women: Physicians who are not trained specifically in treating older women may make an incorrect diagnosis–leading to delayed or incorrect treatment or a misdirected referral.

- ♀ Uninsured mid-life and older women are especially at risk as managed care ratchets down payments to physicians and hospitals which, in turn, reduce the amount of uncompensated care provided to the uninsured.

- ♀ Concerns have arisen about women enrolled in Medicare managed care plans–in particular, disruption of patient-provider relationships, difficulties gaining access to specialists and prescription drugs, and shortened or nonexistent hospital stays for various operations.

Recommendations
Mid life and older women should press for needed reforms including:

- ♀ enrollee protections for full access to appropriate specialty care: including use of specialists as primary care physicians

- ♀ strengthened internal and external grievance and compliant procedures; including a complaint mechanism that allows the recovery of costs;

- ♀ prohibitions against gag rules restricting providers from advising patients about more costly treatment options;

- ♀ access to a full range of available treatments; including prescription drugs and mental health treatments; and

- ♀ enforceable standards that guarantee quality care.

Until comprehensive national health care reform is achieved, mid-life and older women can best protect themselves in this rapidly changing health care environment by improving managed care delivery and learning all that they can about managed care.

Making educated health care choices is more important than ever. Mid-life and older women need information about managed care plan rules, options for speciality care, and grievance and appeal mechanisms. Should problems in gaining access to health care services arise at a later date, women are in a much stronger position if they have educated themselves at the outset.

What the Women's Health Initiative Means for Black Women

The Women's Health Initiative (WHI) is the largest prevention study ever funded by the National Institutes of Health. Results from the WHI will once and for all provide women with the information they need about the role of hormone replacement therapy, dietary changes and calcium/vitamin D supplementation in the prevention of heart disease, cancer and osteoporosis in postmenopausal women. Heart disease is the leading cause of death among all women, and breast cancer is second only to lung cancer as the leading cause of cancer deaths in all women, including African American women. In fact, Black women are almost four times more likely to die of coronary heart disease than white women,

and, while breast cancer is less common in Black women, they have a higher mortality rate than white women.

The WHI is unique in that this clinical trial and observational study will include the largest ever population of minority women, including Black women, in order to understand the roles culture, lifestyle, genetics and environment play in the risk of various health problems. To adequately study Black women and other women of color, 20 percent of the 164,500 women participating in the study will be recruited from minority populations. The 20 percent recruitment goal means that minority women will be represented in the WHI at least in the proportion that they are found in the general population. As a result of this study, large pools of data, from both the clinical trials and the observational study, will be obtained on the health status, diets, lifestyles, family histories, health habits and attitudes of Black women. Using this information, researchers will gain valuable insight into the health of post-menopausal Black women and how to prevent conditions which affect their lives.

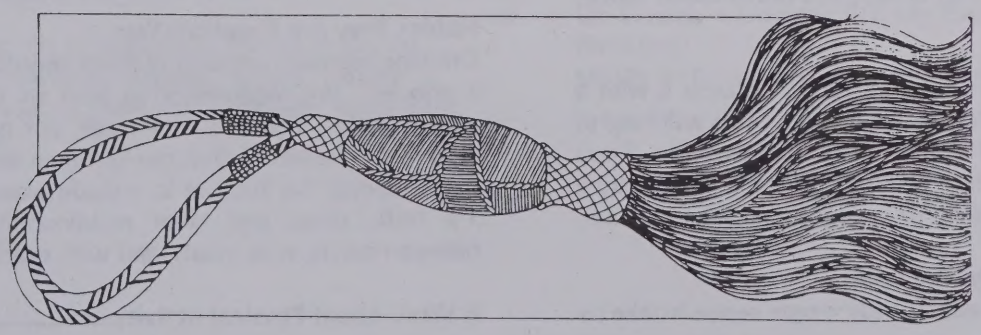
Recruiting thousands of Black women for the study is a challenge, but the WHI is meeting, if not exceeding, its goal through a number of targeted activities. First, five of the 40 WHI clinical centers have been funded to recruit a majority – 60 percent of their total study population – of African American women. These centers are located in Atlanta, GA; Birmingham, AL; Washington, D.C.; Detroit, MI; and Chicago, IL – all areas densely populated by Black women. Several other WHI clinical centers are located in areas that also have large populations of Black women. These sites are in New York, NY; Los Angeles, CA; Memphis, TN; Newark, NJ; and Winston-Salem, NC.

Secondly, WHI clinical centers targeting Black women have adopted community-based recruitment strategies that include input, guidance and assistance from advisory boards made up of local leaders in the African American community. In addition, WHI recruitment coordinators conduct outreach with Black churches and community centers and include African American co-investigators and staff in all of their presentations and other activities. The WHI additionally has emphasized the development of culturally relevant educational materials.

At the end of September 1996, more than 6,900 Black women ages 50-79 had joined the WHI. Thousands more Black women, particularly those over age 65, are needed in order to ensure the study's success. Results from the WHI will than provide valuable information to Black women and their physicians about measures they can take to improve their health. Women interested in learning more about how to join the WHI should call 1-800-54-WOMEN for more information.

NOTE: Byllye Avery, founder of the NBWHP, serves on the Advisory Committee for the Office of Research on Women's Health. This committee oversees the Special Ad Hoc Working Group on the WHI, a non-federal panel of physicians, researchers and women's advocates.

Co-Authored by: Vivian W. Pinn, M.D., WHI Co-study Chair and Director, Office of Research on Women's Health; Loretta P. Finnegan, M.D., Director of the Office of the WHI; Barbara V. Howard, Ph.D., Principal Investigator, Medlantic/Howard University Clinical Center



NUTRITION

NUTRITIONAL WELL-BEING IN OLDER ADULTS

The dietary requirements of older people are sometimes different from those of younger adults. Meeting these requirements to avoid nutrient deficiencies is an important challenge that older people must face. A sensible diet and regular exercise are two important keys to a healthy and vigorous life- no matter what your age.

As a healthy older adult, some of your dietary needs may be different from what they were in your youth, while others may be similar. This is really crucial of African Americans because as a group, we tend to weigh more than our older, ethnic counter-parts. Continue, or begin to implement the following recommendations on a regular basis, for a healthier you.

Enjoy Eating While Watching Out For Fat
An eating pattern that is low in fat, especially saturated fat, and cholesterol, and that has an adequate amount of fiber is essential to your well-being. To accomplish this, make plant foods - cereals, grains, vegetables, and fruits - the basis of your diet. Also, choose 1% or skim milk and animal flesh (poultry, fish, meat), in moderation, to round out your nutrient intake. Remember, use gravy, oils, margarine, cheese, cream, and butter-based sauces sparingly.

When you eat a high-fat food, balance it with a lower - fat choice during the day. This will help to keep your total fat intake low. For example, if you have a hamburger and french fries for lunch, try a low-fat meatless entree or vegetarian dish for dinner.

Keep An Eye On The Scale
Maintaining a healthy body weight seems to take on a greater significance for many of us as we age. Whether we are overweight, try to do some activity every day. Brisk walking, for example, can help to take, then keep those pounds off. We recommend doing this four or more times each week. Check with your doctor before you begin any increased activity. If you find it difficult to lose weight, at the very least, do not gain any more. Many of us need fewer calories as we age, but more of other nutrients such as vitamins, mineral and fiber. Enjoying a low-fat diet can deliver those nutrients without excess calories or fat.

Watch Out For That Salt
Go easy on sodium (salt) intake. Experiment with, and enjoy a wide variety of spices and herbs. This way you will use less salt. Also eat less foods that are high in sodium. These include processed meats, such as ham, bacon, scrapple, hot dog, and luncheon meats; pickles, regular soy sauce, regular cheese, and salted snack foods. Be sure to read labels to see the sodium content of the foods you buy. Always purchase low-sodium or reduced-sodium varieties of four favorite brands. You can also rinse canned vegetables to help remove much of the sodium they contain.

Fluids - They Are Good For You
Drinking adequate amounts of fluids should also be a priority. We recommend at least six to eights glasses daily. You see, as we age, our needs for fluids stays the same. But, our ability to feel thirsty may decline. So, be sure to include water, juice, 1% milk, soup, and other nonalcoholic fluids between meals, with meals, and with snacks.

A Word About Physical Activity.....

Did you know that physical activity can:

- give you added strength and energy so you can do more for yourself and reduce the risk of accidents?
- keep your bones strong to prevent fractures, osteoporosis, and improve your posture?
- increase the amount of muscle on your body and decrease the fat? More muscle can mean healthier metabolism and reduced risk of diabetes, heart disease, high blood pressure, and obesity.
- build a stronger heart and efficient blood vessels?

Choose activities you love and start gradually. First, see your physician to assess your particular health needs and limitations. Whatever you choose make sure you enjoy it

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Enjoy these lower-fat choices each day:

FOOD GROUP	DAILY SERVINGS
Bread, cereal, rice, pasta	**6 - 11**

Choose: bread, low-fat crackers, bread sticks; cereal; rice, pasta, non-fat or low-fat cookies and cakes, pretzels, etc.

Vegetables	**3 - 5**

Choose: greens (collards, mustard, etc.), string beans and other varieties, carrots, corn, potatoes, yams, broccoli, peas, romaine lettuce, etc.

Fruits	**2 - 4**

Choose: oranges, grapefruits, bananas, apples, pears, peaches, melons, berries, etc.

Milk, yogurt, cheese	**2 - 4**

Choose: 1% or skim milk, non-fat or low-fat yogurt, lower-fat cheeses, ice milk, low-fat frozen yogurt; puddings made with 1% or non-fat milk.

Meat, poultry, fish, egg, dry beans, peanut butter	**2 - 3**

Choose: skinless chicken and turkey (the breast and drumstick are less fatty); fish and shell fish; lean cuts of red meat; dry beans; nuts; egg whites or cholesterol-free egg substitutes. **(Cholesterol-free egg substitutes are high in sodium so be careful if you have high blood pressure or other illnesses that may warrant a low sodium diet.**

Regular physical activity and eating a variety of foods from among all the food groups listed above will go a long way toward establishing overall good health in people of all ages. This approach to a healthy lifestyle is especially needed for us, as older African American women, as we celebrate life to its fullest.

Dr. Goulda A Downer, RD, LN, CNS
President,
METROPLEX Health and Nutrition Services, Inc.

HOLISTIC HEALTH

ESTROGEN: THE NATURAL WAY

Nina Shandler

ALMOST COFFEE BY THE MUG
Work and Cooking Time: Under 5 minutes
Yield: Makes 1 Serving
Plant Estrogen Estimate: 1 Portion Per Serving

It's not coffee! But it is good, easy, quick, healthy, and phytoestrogen-filled.

Grain coffees like Cafix, Postum or Pero don't cover the taste of soy any better than small quantities of chocolate or vanilla. To really make a hot grain-coffee drink tasty, you need to add more flavoring. You can, of course, bring grain coffee to a whole other level of enjoyment by steaming it. Soy milk bubbles and froths better than most any milk-certainly better than skim milk.
1 cup soy milk
½ teaspoon ground cardamom or nutmeg
1 teaspoon grain coffee or almond extract

Heat the soy milk. Dissolve the grain coffee in the hot milk. Stir in the spice or flavoring.

BANANA-NUT MINI MUFFINS
Work Time: Under 10 minutes
Baking Time: 40 minutes
Equipment: Electric blender
Yield: Makes 24 mini-muffins
Plant Estrogen Estimate: Nearly ½ portion per muffin

Thanks go to natural banana flavor for the taste of these not-too-sweet muffins. One banana gives only a hint of banana taste. More than one banana makes for paste like insides. Natural banana flavor is the perfect solution.
2 cups unbleached white flour
1/3 soy flour
2 teaspoons baking soda
2 cups soy milk
1 banana, sliced
½ cup all-fruit apricot jam
1 tablespoon vanilla extract
3 tablespoons natural banana flavor
2 tablespoons lemon juice
½ cup flaxseed
2/3 cup coarsely chopped walnuts

6.Preheat the oven to 325°F.
7.Place all of the dry ingredients in a medium-size mixing bowl. Stir with a wire whisk until completely combined.
8.Place the remaining ingredients, except the walnuts, in an electric blender. Blend until the flaxseeds begin to disintegrate and the mixture bubbles. Pour into the dry ingredients. Stir to form a batter. Add the walnuts and stir to combine.
9.Spoon into twenty-four nonstick or oiled mini-muffin tins, filling to the top. Bake for 40 minutes, until browned and firm to the touch.

SPINACH QUICHE
Work Time: Under 15 minutes
Baking Time: 1 hour
Equipment: Electric food processor
Yield: Makes 6 servings

Plant Estrogen Estimate: 1 portion per serving
This colorful quiche has a light nutmeg flavor.

4 garlic cloves, quartered
1½ cakes (24 oz.) extra-firm tofu
½ teaspoon turmeric
½ teaspoon ground nutmeg
3 tablespoons Dijon mustard
1 onion, chopped
20 oz. fresh spinach, steamed and chopped or frozen chopped spinach, thawed

1.Preheat the oven to 350°F.
2.Place the garlic in a food processor with the S blade inserted. Mince. Break the tofu into small pieces and place in the food processor. Add the turmeric, nutmeg, and mustard, Process for 3 minutes, until smooth.
3.Turn into a medium-size mixing bowl. Add the onion. Squeeze all the water out of the spinach. Add. Mix until thoroughly combined. Turn into a 9-inch nonstick or oiled pie plate. Bake for 1 hour, until set. Unmold onto a dinner plate. Allow to cool for 5 minutes before serving.

ROASTED GARLIC, WHITE BEAN AND SAUSAGE SOUP
Work and Cooking Time: Under 15 minutes
Equipment: Electric food processor
Yield: Makes 4 servings
Plant Estrogen Estimate: 2 portions per serving

Creamy without cream. Soy sausage, tofu, and soy milk provide natural estrogen. To save time, use bottle roasted garlic cloves.
Spray oil
10 soy sausages, sliced drained
3 garlic cloves, quartered
1 cake (16 oz.) soft tofu
2 tablespoons whole roasted garlic cloves
2 tablespoons dark miso
15 oz. can white or great northern beans, drained
1½ cups unsweetened soy milk
1/4 cup chopped roasted garlic cloves
1 tablespoon mustard seed
Pepper

1.Spray a heavy-bottomed soup pot with oil. Saute the sliced sausage over medium-high heat.
2.While the sausage sautes, place the fresh garlic in a food processor with the S-blade inserted. Mince. Add the tofu, 2 tablespoons roasted garlic, and miso. Process for 2 minutes, until smooth and silky.
3.Add the tofu mixture, the beans, soy milk, 1/4 cup chopped roasted garlic, and mustard seed to the sausage. Reduce the heat to medium and stir until all of the ingredients are well combined. Cook, stirring occasionally, without bringing to a boil, until heated through. Season with pepper before serving.

STRAWBERRY SORBET
Work Time: Under 5 minutes
Equipment: Electric blender or electric food processor
Yield: Makes 4 servings
Plant Estrogen Estimate: 1 portion per serving

Strawberries are a great source of boron – one of the best bone-protective minerals.
16 oz. pkg. frozen unsweetened strawberries
1 cake (19 oz.) silken tofu
½ cup all-fruit strawberry jam
1 teaspoon vanilla extract
1 teaspoon lemon extract

Place all of the ingredients in an electric blender or food processor with the S blade inserted. Blend or process until thick and creamy. Taste. If needed, add more vanilla or lemon extract. Serve immediately.

Reaping the Potential Benefits of Soy	
Decrease breast cancer risk	1 - 2 portions
Reduce menopausal symptoms	1 - 2 portions
Lower cholesterol	2 - 5 portions
Approximate a bone-protective dose of pharmaceutical estrogen	3 - 8 portions

One Portion of Soy Equals		
1 cup soy milk	½ cup soy flour	½ cup soybeans
1/4 cup TVP	1 soyburger	1/3 cup dry-roasted soy nuts
1/4 cake tofu	2 soy hot dogs	

Reaping The Potential Benefits of Flaxseed	
Approximate a bone-protective dose of pharmaceutical estrogen	3 - 8 tablespoons
Decrease breast cancer risk	1 tablespoon
Reduce menopausal symptoms	2 - 3 tablespoons
Lower cholesterol	2 - 5 tablespoons

HERBAL FOOD FOR BETTER HEALTH

Herbs are a wholesome, natural food for the body. Herbs are a mere dietetic aid in the process of rebuilding, normalizing, and maintaining the functioning of the body. To put it simply, herbs help the body to stay healthy.

Aloe One of the great healing agents we have among the herbs. Works wonderfully in cleaning out the colon. Gives regular bowel movement. Aloe works well on any kind of sore on the outside of the body. Excellent for piles and hemorrhoids.

Black Cohosh Useful in estrogen production and ovulation. It helps enable transport of estrogen throughout the body. It strengthen the uterus. It is good for irregular or scanty menstruation with muscular aches and pains. It helps during menopause.

Blessed Thistle It increases production of mother's milk. It balances hormones and can health with infertility. It is a tonic and blood purifier. Good for menopause, to balance hormones.

Burdock Leaf & Root Extremely good for removing toxins from the body. Strong blood purifier and cleanser. One of the best herbs for severe skin problems. Good for advanced cases of arthritis. Its insulin content aids the pituitary gland in releasing an ample supply of protein to help balance hormones.

Dong Quai Root This is a most wonderful herb for female trouble. It can help decrease the discomfort in premenstrual syndrome and menopausal synptoms. It is beneficial for candida and enhances the immune system; promotes healthy arteries and blood vessels. It is rich in vitamins B-12 and E.

False Unicorn It stimulates the reproductive organs in women and men. It is used in herbal combination to correct almost all problems of the reproductive organs. It is effective during menopause because of its effect on uterine disorders, headaches, and depression.

Fever Few Herb Anyone who suffers from migraines should give this herb a try. It works wonders in fighting against migraines. Thousands have successfully been helped without any side effects. Other benefits of this herb are: helps reduce inflammation in arthritic joints and has been used to restore the liver to normal function.

Hawthorn Hawthorn is highly regarded for its benefit to the heart. It is used to strengthen and regulate the heart. Good for people under stress. Useful in treating high and low blood pressure. Very effective in relieving insomnia.

Sarsaparilla Root It helps in progesterone stimulation, which sustains pregnancy and relaxes muscles. It is a natural diuretic and digestive aid.

Nervine Chamomile, Hops, Passion Flower, Lady's Slipper, Scullcap, St. Johnswort and Valerian Root all help in strengthening the nervous system and prevent wearing away of the nerve sheath. They are soothing and calming to help women cope with the stress of daily living.

In the United States, homeopathy is practiced by medical doctors, osteopathic physicians and other licensed health professionals, including nurses, physician's assistants, dentists, veterinarians, chiropractors, acupuncturists, naturopaths and psychologists. There is also a growing number of Lay persons.

For chronic problems and/or serious health concerns you should consult a homeopathic practitioner rather than treat yourself with the homeopathic remedies. In some cases, remedies are easily inactivated or antidoted, so that it is important to get expert guidance on what special precautions you need to take. Once you become more knowledgeable about homeopathic remedies, first aid kits and books may also be useful in helping you to treat simple problems safely at home.

SISTERNET

Older Women and Computers? Yes!

Mid-life and older women have begun embracing computers and related technologies like modems and CD-ROMS. In fact, the 1994 Times Mirror Survey of Technology found that computers were present in the households of 30 percent of women ages 45 to 64. However that percentage dropped to a mere six percent for older women. Men were a lot more likely to have computers at home. The survey found that 39 percent of mid-life men and 16 percent of older men owned computers.

Even when a woman does have a computer in the house, that doesn't necessarily mean she's the one who's using it. When the survey asked women computer owners whether they had used their home computers the previous day, only nine percent of the mid-life women and two percent of the older women said yes. In contrast, 20 percent of mid-life men and eight percent of older men answered positively.

Eye-popping price tags are probably one reason mid-life and older women – whose incomes are typically lower than men's – aren't rushing out to buy computers. But cost doesn't have to be an insurmountable problem. "If women really want access, they can get it," claims Ellen Pack, co-founder of an on-line service called Women's Wire. "Secondhand models are cheap and perfectly adequate for most women's need," she says. And more and more libraries have free computing facilities.

"Cost is not the biggest barriers," says Pack. "The technology is. Computers are still not a tool that every older women feels comfortable with. There's a sense that it's harder to do than it really is ."

The fact that older women are less likely than other groups to have encountered computers during their working years is one factor contributing to this mystique. Other factors that keep older women away are the sexism of some sales clerks and media reports of sexual harassment within the realm of on-line services.

A lot of women don't get hooked until they go on-line, using modems to connect their computers with other computers. Most women find that the world of "cyberspace" has much more to offer than its seemingly inexhaustible supply of information.

For example, being on-line makes friendship available even to women so frail they can't leave their homes. For women who aren't housebound, on-line friends can complement a full social life. Free advice is another benefit. Care givers, for instance, can not only find information but can also share their experiences with other Care givers. "Some of these women can't get out to support groups and they're not necessarily in the workplace," says Gail Gibson-Hunt of Gibson-Hunt Associates, a Washington, D.C., consulting firm focusing on aging issues. Activism is another popular on-line activity. A computer can facilitate your volunteer projects since when you retire, you lose your support services. The computer gives them back. It's an adjunct office," offers Mary Gardiner Jones, a former Federal Communications Commissioner who now heads the Alliance for Public Technology. These activities are just the beginning. Older women can't be technology

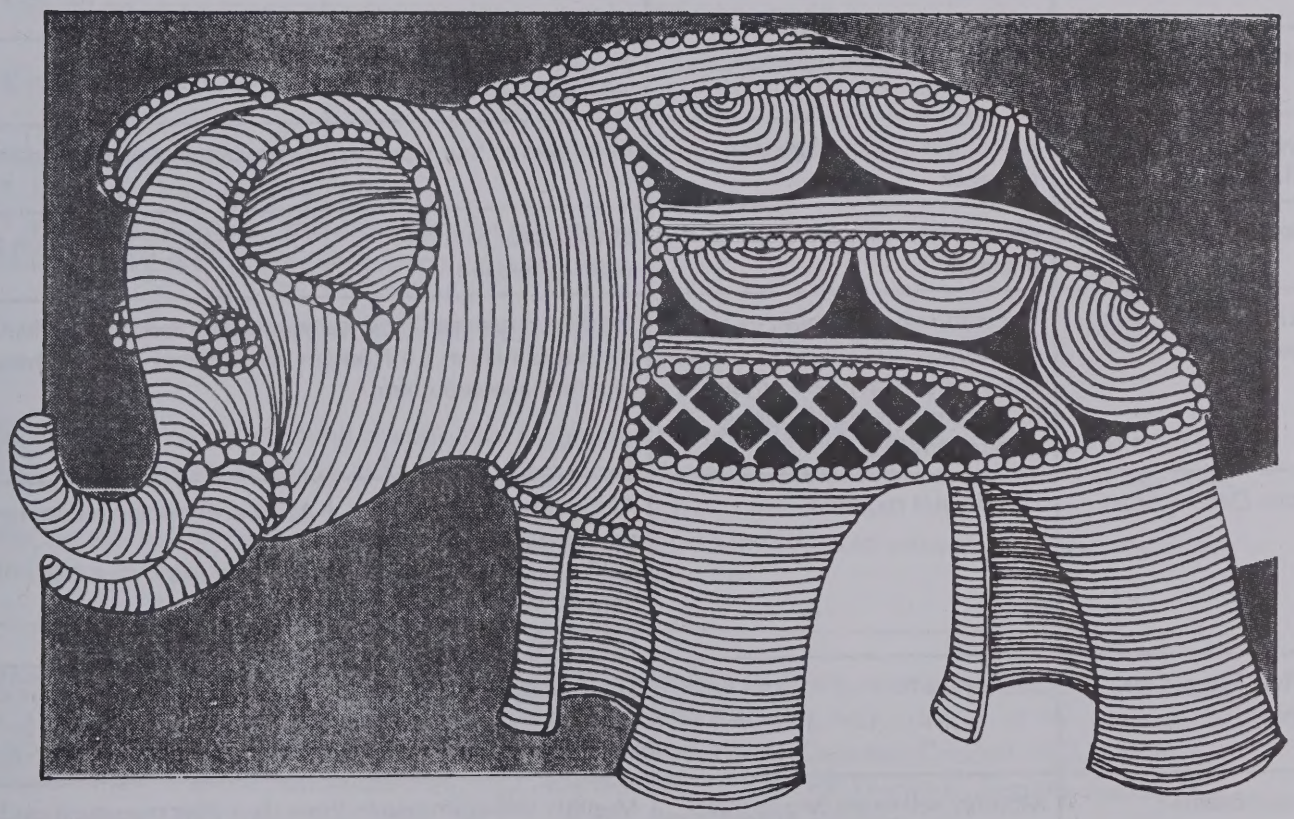
averse or they're really going to be left out," says Hunt.

Resources

A nonprofit organization called **SeniorNet** offers computer instruction for people 55 and over at 75 learning centers across the country. Call 800-747-6848. The **Alliance for Public Technology** works to make technology accessible to all. Call 202-408-1403. American Association of Retired Persons' **AARP Online** allows participants to talk about various fields, and other subscribers; a Care giver support group, for example, meets weekly in an on-line "chat room." The service also offers a wealth of information, including electronic "Bulletin Boards" and many publications on women's issues. The service is accessible through the three largest commercial services. Call 800-827-6364 for **America Online**, 800-848-8199 for **CompuServe**, and 800-776-3449 for **Prodigy.** Also try **Women's Wire,** a service focusing specifically on women's issues. Call 800-210-9999.

Reference:

"Older Women And Computers? Yes!," ***AARP* WIN** *Women's Initiative Network*, Volume 6, Number 2, Fall 1995. A networking newsletter for and about the people, programs, and issues of AARP's Women's Initiative. 601 E. Street, NW, Washington, DC 20049.



FOR WOMEN ONLY

A TIMETABLE FOR MAINTAINING GOOD HEALTH

This chart is a basic guide to the medical evaluations a woman should have throughout her adult life. It does not take into consideration any existing symptoms or family history of disease.

Test	18 to 34	35 to 49	50 plus
General Physical	Every one to three years.	Every year.	Every year.
Blood Pressure	As part of general physical every one to two years.	As part of general physical.	As often as your personal history dictates.
Cholesterol	Every five years.	Every five years.	Every three to five years.
Hearing Test	As part of general physical.	As part of general physical.	Periodic testing after age 65.
Rectal Exam	Usually not required.	After age 40.	Sigmoidoscopy-every 3 to 5 years. Check stool for blood.
Urinalysis	As part of routine prenatal care.	As part of routine prenatal care.	Routinely from age 60.
Eye Exam & Glaucoma Test	Visual test as part of general physical.	Every two to four years.	Every one to two years after age 65.
Dental Care	Once a year or more often as needed.	Once a year or more often as needed.	Once a year or more often as needed.
Skin Cancer Check-ups	*The information applies to all age groups.* Ask your primary care physician to perform this check during general physical.	Become more familiar with your moles and birthmarks. Check them routinely in a full length mirror (front and back) for changes in size shape and color.	
Bone Density Scan	Usually not required.	At the onset of menopause. Discuss HRT, your risk and/or benefits with your physician.	As your physician recommends.
Pelvic Exam, Pap Smear	Every year.*	Every year.* Frequency based on physician Discretion. *After 3 consecutive normal tests, the pap smear can be performed every one to three years sue to age, risk, and physical discretion.	
Breast Exams	Monthly self-exam two to three days after menstrual cycle. Physician exam every one to three years.	Monthly self-exam two to three days after menstrual cycle. Physician exam every year after age of 40. Have a mammogram every one to two years from age 40-49. Annual mammogram after age 50.	

When you take responsibility for your own health there are basic recommendations to follow:

* Eat a balanced diet low in fat and high in fiber to guard against cancer and heart disease.
* Eat dairy products and other calcium rich foods to guard against osteoporosis.
* Do aerobic exercise for at least 20 minutes a day three times a week.
* Don't smoke. If you do, quit now.
* Always wear seat belts in a car.
* Practice safe sex.
* Limit your exposure to the sun.
* Keep up to date on immunizations.
* Know your body and be alert for changes.
* Discuss the pros and cons of Hormone Replacement Therapy (HRT) after menopause with your health care provider.
* Be aware of the signs and symptoms of major diseases.
* Don't be afraid to voice your concerns to your health care provider.

Know When You Need a Specialist:

Some of life's simplest pleasures
* laughing, walking, exercising
* may be a source of embarrassment for women who suffer from Incontinence. Most women don't realize that a urologist or urogynecologist can help.

An adolescent gynecologist specializes in treating younger women and is sensitive to their special concerns.

Starting a family is something couples take for granted but infertility affects one in seven couples in the U.S. The infertility specialist at Penn are internationally recognized for their contributions in this field.

For the evaluation and treatment of gynecologic cancers, it's important to see a gynecologic oncologist for specialty care and access to the newest treatment options.

The following providers from the University of Pennsylvania Health System contributed to this chart:
Todra Anderson, MD, Adolescent Gynecology; Michelle Battistini, MD, Director of Penn Health for Women; Christos Coutifaris, MD, Ph.D., Human Reproduction; Deborah Driscoll, MD, Adolescent Gynecology; Valerie Fornasieri-Weil, MD, Internist Penn Health for Women; Stephen Rubin, MD, Gynecologic Oncology; Gita Singh, MD, Urologist, Penn Health Women.

Integrity

When what you say
And what you do
Line up as though they're one
That's integrity.

When the things
That you have said
Are the things that you have done
That's integrity. *Paula Cole Jones*

Mrs. Lillie Allen-Steadman was born in Elberton, Georgia on September 17, 1915, the first born child, to Mrs. Alice (housewife) and Mr. Johnny Toombs Allen (the first known black stone polisher - a trade for Greeks and Italians). Elberton, Georgia is the Stone Capital of the world. She helped her mother take care of her 2 younger sisters and 3 younger brothers until she left Elberton for Atlanta, Georgia, with her grandparents, Mr. and Mrs. Orah Brawner. She has one remaining sibling, a sister, Mrs. Cora A. Eberhardt, who still resides in Elberton.

After moving to Atlanta, she worked as a cook to help pay bills. This was during the Great Depression. She worked days and went to night school. During that time there was almost as many night classes as day classes. The available jobs for women of color during that time included doing laundry, cooking and caring for the children of white families. Those lucky enough to know how to cook were able to get good jobs working in rich white homes where you only cooked or cared for the children.

She was employed as a cook for some of the most prominent families in Atlanta, including the Rich and Montag families. These families were world travelers who knew the value of good staff. The would routinely travel for two or three months at the time and their staff would continue to receive their pay while their employers were out of town.

From the Community

Lillie Allen-Steadman

After completing high school she attended Morris Brown college for three years. She later married Joseph Harvey Steadman, originally from Goldsboro, North Carolina, who came to Atlanta seeking employment. Mr. Steadman, who had a degree in architecture from Hampton Institute (now University), found work as a carpenter, building FHA houses. For years Mrs. Steadman was a housewife and mother. She is the proud mother of Orah B. Harris (deceased), Darney, Joseph, Jr., John, Danise, and Debra, the proud grandmother of twenty-two grandchildren and over twenty great grandchildren.

When her youngest daughter, Debra reached school age, she returned to the work force. Mrs. Steadman joined many organizations. She was involved with the Parents Teachers Association for over 50 years. During this time, she helped to integrate the Atlanta City Schools. She served as correspondence secretary of a group of strong black women, the Negro Women Voters League. Some of its members were, Mrs. W.A. Scott, Mrs. L.B. Blayton, Mrs. Doris Blayton, Mrs. Ruby Blackburn, Mrs. Frances B. Fouch, Mrs. Geneva Haugabrooks, Mrs. Lillie Moreland, Mrs. Lucille Hunt, Ms. Vasti Scott Ellis, and many more. Mrs. Steadman is the only surviving member.

On a cold winter day, she and other members of the Negro Women Voters League (League) helped to integrate the Georgia Assembly (at the Georgia State Capital). That day about 10 of the League members went to the Georgia General Assembly and sat down on the other side. The General Assembly, (at that time was made up of white men), didn't tell this group of strong, well dressed, well-behaved, black women to leave. Members of the Georgia State Assembly simply opened the windows on the side where the League members were sitting. But, these women continued to sit there. The General Assembly realizing that despite the cold air coming in on these black women they intended to remain

steadfast, adjourned early for the day. These women returned for several days, until, eventually, they let these women stay. The following year the League had a lot of Blacks join their cause - integration - and the rest is history (herstory). That was the beginning of Blacks being voted in office.

While working for the cause - integration and equality for schools - Mrs. Steadman met a kind white women by the name of Phoebe. Phoebe and Mrs. Steadman worked, shared tips and strategies, as well as compared notes at meetings and over the phone. Years later, as a member of the National Black Women's Health Project Mrs. Steadman met her sister, Lucinda Bunnen, who helped the Project obtain it's Atlanta office "Phoebe House," affectionately called the Mother House .

The League was also instrumental in getting public transportation in the community and the west side of Atlanta. The transportation charter was bought from a Jewish man to bring in the Atlanta Transit System (now known as MARTA). At one time that bus line had the most frequently running buses – 46 buses in one hour.

Mr. Steadman died in January 1963. This was a low period for Mrs. Steadman. That same year, a group of college students came down from the North to Atlanta and helped register over 5,000 people on the West side of Atlanta. At that time, Mrs. Steadman was president of the Anderson Park Elementary School PTA, and along with a group of diligent, hard-working parents that worked hard to improve this proud community, worked to register 3,000 voters in one week!

After the death of her husband, Mrs. Steadman worked for a while at the same job, then returned to school, once again. This time she studied elementary education and taught pre-schoolers for a few years. She later taught arts and crafts to senior citizens.

Ms. Steadman has been a member of the National Black Women's Health Project almost since its inception. She began working as the NBWHP in 1983. January 1997 marks 14 years Mrs. Steadman has been with the Project. She has brought many members to the Project, including her sister, cousin, daughters and granddaughters. Her daughter, Darney Stevenson volunteered her services to the project in the beginning. And her granddaughter, LaWarna Stevenson is trying to start a group at her school.

Although she has cut back on some of her activities, Ms. Steadman continues to sing the NBWHP praise. In addition, Mrs. Steadman still contributes to the March of Dimes, Cancer Society, Disabled Veterans, Atlanta Union Mission, Carrie Steel Pitts Home, Homeless Women Shelter, Lung Association, as well as contributing school supplies to needy children.

For the past 9-10 years she has been an active member of the Older Women's League (OWL). In fact, she was one of the first black females to join and presently serves on the Board.

Mrs. Steadman, along with other women and men from the NBWHP, OWL, American Association of Retired People and other groups diligently worked in several districts in Georgia to start a "Hands Across America" group to serve Georgia. This group worked in Macon, Savannah and Atlanta. Hands Across America is still going strong.

Ms. Steadman, a Charter member of Benson Temple People's Free Methodist Church (for 56 ears), has received citations for her dedication. Until December 1996, when she voluntarily stepped down from her position as a Trustee, she was the oldest member of the Trustee Board. Although Mrs. Steadman is cutting back on some of her activities, she intends to "go down swinging" and "serving the Lord".

Thank You, Ms. Lillie Allen-Steadman, from all of your sisters. We love you ♡

"COMING BACK STRONG"

NATIONAL BLACK WOMEN'S HEALTH PROJECT
WELLNESS CONFERENCE AND ANNUAL MEETING
JUNE 27-28 1997
Detroit, Michigan

Cobo Conference/Exhibition Center
One Washington Blvd.
(313) 877-8777

Friday, June 27,1997

9:30 a.m.
Opening Welcome
Cynthia Taueg, Director
Detroit Department of Health

Special Tribute To Ronda Adams and Juanita Berry

10:00 a.m.
Health Status of African American Women
Vernice Davis-Anthony, Sr. Vice President
Urban and Community Health
St. Johns Health System
Detroit, Michigan

10:30 a.m.
Wellness and the Vision of National Black Women's Health
Byllye Y. Avery, Founder

11:00 a.m.
Walking for Wellness Protecting Hearts, Saving Lives
Moderator: Byllye Y Avery
Salima Marriott, Baltimore BWHP
Gwen Winston, Detroit BWHP
Katrina McGhee, American Heart Association

12:00-1:00 p.m.
LUNCH ON YOUR OWN

1:00 - 2:00 p.m.
Self-Help/Wellness

2:00- 3:00 p.m.
Public Policy Implications Health and Welfare Reform
*Rep. Carolyn Kilpatrick - **Federal Update**
Holly Mitchell - **State Issues**
California Black Women's Health Project
Marian Kramer - **Implications for Low-Income Women**
Co-President, National Welfare Rights Union

3:00-5:00 p.m.
Annual Meeting
Chair's Report - Akua Budu-Watkins
President's Report - Julia R. Scott
Treasurer's Report - Etienne LeGrand
Committee Reports
Membership Development - Fran Frazier
Sylvia Quinton
Nominations/Elections - Sharon Edwards
Program - Shiriki Kumanyika
Fundraising - Byllye Y. Avery

Recognitions
Walk for Wellness Logistics

6:00 -8:00 p.m.
Author's Reception
National and Local Authors

Saturday, June 28, 1997

8:00 a.m.-12:00 p.m.
Walking for Wellness, Belle Isle Park
Health Screenings
Education
Entertainment

2:00-5:00 p.m.
Mobilizing Walking for Wellness in Your Community
Byllye Y. Avery
Meta Mendal-Reye
Swarthmore College
Swarthmore, PA

Adjournment

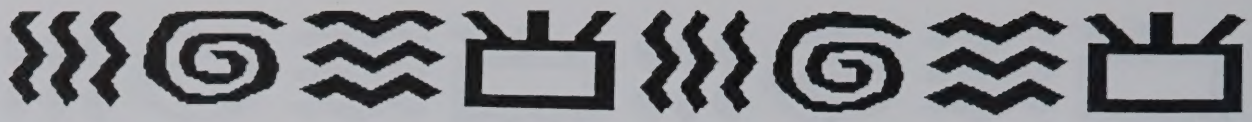
Sunday, June 29, 1997

9:00 a.m-12:00 noon
Sister Spirit Celebration
Conducted by the Sisters from Ohio

A spirit-filled morning focused on ministering to the needs of Black women; including drumming, good preaching and an opportunity to tell your story. The morning will end with a healing ceremony designed to lift your spirits and celebrate our specialness as a Black women!

* Invited

PLEASE NOTE - The actual conference events will take place at the Cobo Conference/Exhibition Center which is located approximately two (2) blocks from the Westin, Doubletree, Crown Plaza Hotel.



THE NATIONAL BLACK WOMEN'S HEALTH PROJECT

1997 Conference and Annual Meeting Registration
Detroit, Michigan

Please print clearly:

Name: _____

Address: _____

City/State/Zip: _____

Phone Number(s): _____

All conference registrants must complete the following information:

Registration Fee (check, credit card or money orders* by June 1, 1997): $_____

Members	$25	***(Before June 1)***
Members	$50	***(After June 1)***
Non-Members	$75	

NBWHP Membership Fee**: $_____

Total Amount Enclosed: $_____

No refund of registration fee after June 1, 1997

I will/will not be a participant in the *Walking for Wellness: Protecting Hearts, Saving Lives* event.

Return this registration form and fees to:
NBWHP
1211 Connecticut Avenue, NW
Suite 310
Washington, DC 20036

Conference Hotel Reservation Information

You must call the hotel to reserve your room.

The Westin Hotel/Renaissance Center at 1-800-228-3000. The group code for NBWHP reservations is **BH5.** In order to be eligible for special room rate of $85 per night the deadline for hotel reservations is June 15.
Doubletree Hotel 1-800-222-8783
Crown Plaza Hotel 1-800-227-6963.

****Only cash, credit cards or money orders will be accepted at the conference.***
Absolutely* NO PERSONAL CHECKS *will be accepted on site.
** See membership form.

The National Black Women's Health Project
Board of Directors
1996-1997

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Public Health Attorney
Deputy Director, Office of Policy and Planning
Center for Substance Abuse Prevention
Rockville, MD

NOTICE NOTICE NOTICE NOTICE

NBWHP Board Of Directors Elections

Traditionally NBWHP has its Board elections at the Annual meeting. However in light of the fact that the organization has been under going a major transition and reorganization the Board has determined we must postpone our elections this year. This will allow us to share with members, at the June 27th meeting, a nomination and election process designed to ensure the representation of Board members that reflects both our philosophy and the expertise needed for the growth and sustainability of the organization.

One of the most critical aspects for the organization's continued growth and development is a strong, committed, national Board of Directors. As such, the Nominations Committee has developed a Board election process that ensures the entire membership can actively participate this year in electing new members to the Board of Directors.

While elections will not be held at the annual meeting, available Board positions will be announced to the membership during the meeting. Board member qualifications and needed skills will be discussed and nomination applications will be distributed. **Sisters interested in being elected to the Board of Directors will complete an application and return it by mail to the national office for review by the Nominations Committee on or before September 1, 1997.**

Potential nominees will be interviewed by the nominations committee by phone, and a slate of Board of Director nominees will be developed for a membership vote by mail in November, 1997. All members will receive mail ballots by November 15, 1997. Election results will be announced in December. New Board member terms will begin, January 1, 1998.

Members of the Nominations Committee and staff will be happy to answer questions about this process during the annual meeting.

Support the Black Women's Health Movement

By designating your
United Way or Combined Federal Campaign
contribution to:

The National Black Women's Health Project #468

We hope you'll consider making a pledge to NBWHP by marking Code #468 on your United Way and\or Combined Federal Campaign (CFC) form. And if you know people in your area who may contribute to United Way or CFC under the auspices of the America Charities, we'd appreciate your spreading the word!

The National Black Women's Health Project (NBWHP), established in 1984, is a non-profit self-help and health advocacy organization whose mission is to improve the health of Black women through the provision of wellness education and services, self-help group development, and health information and activism.

Our self-help program is the outreach vehicle through which the majority of our organizing, leadership development and advocacy are conducted. The self-help process, used to unearth vital health information, allows each participant to analyze her health status and understand how her decision making abilities can impact her health status. The process of empowerment encourages responsibility and commitment to change. This strategy allows us to monitor public policy which affects the wellness of Black women; to interpret and disseminate information regarding the health of Black women and their children; and to educate and train members.

The National Office is located in Washington, D.C. The Project has members world-wide. Sixteen chapters, and 150 self-help groups have been established to facilitate and promote the programs of the Project. Right now, NBWHP sponsored programs provide:

- self-help group development;
- advocates for health care access and reproductive rights;
- a clearinghouse which functions as an information-exchange for Black women's health issues;
- a structured exercise program that promotes wellness through group walking, good nutrition and health education;
- a substance abuse prevention program on seven Historically Black Colleges and Universities promotes healthy living and health advocacy;
- a newsmagazine that provides lively and thought-provoking dialogue by Black women about their health issues.

National Black Women's Health Project
1996 - 1997
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Thank You For Supporting The Building of a National Black Women's Health Movement

EMPLOYMENT OPPORTUNITIES

The National Black Women's Health Project is a self-help and health advocacy membership organization committed to the empowerment and improved health status of African American women. The core program is based on wellness and health promotion. Its organizing and leadership development model is based on the concept and practice of self-help and the inclusion of all women of African descent with a special focus on women living on low-incomes.

The NBWHP is seeking to fill the following positions:

Senior and Associate Program and Policy Organizers
The qualified candidates must have a minimum of 2-5 years experience working in a membership organization and grassroots community organizing; training skills; be committed to the concept of self-help, the right to reproductive choice and the empowerment of women; be knowledgeable of women's health policy issues, have excellent writing, organizational and interpersonal skills; word processing and computer skills; able to travel extensively.

Executive Assistant
Plans and coordinates varied and complex secretarial, confidential and administrative operations for the President. Extensive knowledge of computers and proficient in word processing. Coordinates production activities for Washington D.C. Office. Must be able to speak to the media and to effectively communicate with a range of people.

Administrative Assistant
Three years progressively responsible secretarial experience including extensive knowledge of computers and proficient in word processing (specifically Wordperfect) and database skills, working knowledge of mailing lists and list processing; Excellent proofreading, grammar, and composition skills.

Vice President of Programs and Policy
This senior management level position assures that NBWHP provides excellent services to its Chapters and members. The Vice President will have primary responsibility for guiding the strategic planning process, will share planning responsibility with the presidency and will take the lead on organizational and programmatic development activities of the national organization

Senior Development Associate
This position will work closely with the President/CEO in all aspects of Fund Development. Four years of development experience, preferably in a women, minority health environment, knowledge of non-profit advocacy and membership organizations. Experience in developing grant proposals for both the corporate and foundation sector.

Send resume to: Office Manager
NBWHP
1211 Connecticut Avenue NW #310
Washington, DC 20036

No phone calls please - Closing Date June 15, 1997

NBWHP is an Equal Opportunity Employer and offers a smoke free environment.

Dear Member:

Hello! The National Black Women's Health Project is interested in what you, as one of our valued members, thinks of the services provided by the organization. We would appreciate it greatly if you would take a few moments to complete and return this survey. Your input means a great deal, as we are trying to strengthen our infrastructure and membership services. Thank you in advance for your time and effort. We at the National Black Women's Health Project look forward to continuing to bring our sisters and the worlds of health care, self help, public policy, education, information, activism, and overall wellness together.

United in Sisterhood,

The National Black Women's Health Project
1211 Connecticut Ave., N.W. Suite 310, Washington, DC 20036
Please mail to above address

1. Is your name and address printed correctly on the mailings? (*Please Circle One*) Yes No
   If it is not correct, make corrections below (*please print clearly*):

   Name:_____

   Address:_____

   Phone: _____

   E-mail: _____

2. Do you...? (*Please check what applies*)

   ___Receive duplicate mailings from the NBWHP?
   ___Not receive the newsletter, *Vital Signs,* and other mailings?

3. Do you think receiving a membership card is important? (*Please check what applies*)
   ___ Yes ___ No

4. Tell us something about yourself so, we are better able to serve you.

Age: ___19 - under ___ 20 - 39 ___ 40 - 59 ___60 - over

Income: ___ 20,000 - below ___ 21,000 - 35,000 ___ 36,000 - 50,000 ___ 51,000 - above

Education: ___No H.S. Diploma ___ H.S. Diploma ___ Undergraduate Degree

___ Graduate Degree Other: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Separated Other: _____

Number of Pregnancies: _____ **Number of Children:** _____

5. Do You have a health challenge? Specify (optional) i.e., high blood pressure, diabetes, cancer, lupus, fibroids, etc.

_____

_____

6. What prevents you from using the services and support of the **NBWHP** national office? (*Check all that apply*)

___There's nothing preventing me from getting help
___It's difficult to reach the office by phone or mail
___I do not know who to contact at the national office for help
___I do not understand the information sent to me from the national office
___I do not get information from the national office
___I do not know what help is available
___Other_____

7. How many **NBWHP** national conferences have you attended? (*Circle the number*)

0 1 2 3 4 5 6 more

8. In general, how satisfied are you with the **NBWHP** national conferences?

Did not attend	not at all satisfied				Very satisfied
0	1	2	3	4	5

9. Please make any comments you want to about what is most helpful, least helpful, and/or could be improved about the NBWHP national conferences:

_____

_____

10. Sometimes it is difficult to be at all meetings. What are some of the reasons you were unable to participate in **NBWHP** national conferences (*Check all that apply*)

___Needed child care
___Too expensive to attend. **NBWHP** should consider reducing the costs of the conferences.
___No transportation
___Other family or personal obligations
___Did not hear about the meeting in time
___I did not like the discussion topic
___I could not get time off of work
___Other:_____

11. What time of year would you be able to give an extra gift to the organization?
(*Please check what applies*)

___January to March
___April to June
___July to September
___October to December
___Anytime
___Unfortunately, I am not in the financial position to make extra donations.

Thank you again for helping us to serve you better!

Support the NBWHP

through

Working Assets: The Better World Fund

Help increase the work of the National Black Women's Health Project every time you make a purchase using your Gold MasterCard or VISA and long distance services. The NBWHP is one of the 36 organizations that receives donations from Working Assets Visa and Mastercard, and the Working Assets Long Distance Telephone Service.

Each time you make a credit card purchase or use the long distance service with Working Assets 10 cents will be set aside for the "Better World Fund." The Better World Fund divides the proceeds among four areas of social concern including: human rights, peace and international freedom, economic and social justice, and environmental causes. The NBWHP falls under the category of economic and social justice. As a customer of Working Assets you will receive a ballot each year so that you can nominate NBWHP to receive a portion of the Better World Fund. In 1996, the NBWHP received $56,000 in proceeds from the Better World Fund.

The VISA or MasterCard offers special introductory rate at 9.9 % which is good for 12 months after the account is opened. There is no annual fee for life and a 25-day interest free grace period. Additionally, the card has extra benefits that will protect your purchases from theft or damage, travel and auto benefits, travel accident insurance and more.

Working Assets Long Distance Telephone Service not only offers the comparable basic rates as other long distance services but has one of the best discount plans in the business, provides the high quality sound, along with the following standard features: easy direct dialing, personalized calling cards, friendly customer service, and everything else you need from a long distant carrier.

For the credit card and/or the long distance telephone service applications call 1-800-788-8588 and begin to let your purchases and services have a purpose by advancing the work of the NBWHP.

Awards Day

Why I Came To NBWHP's Center for Black Women's Wellness

By Teresa Wynn

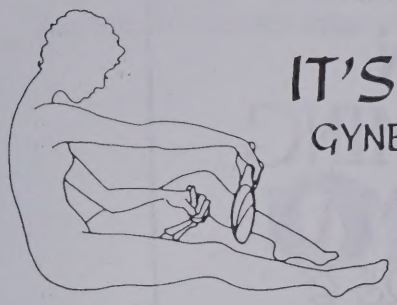
Last fall I was watching television and my son Jarrod came and asked me to read to him. I couldn't, I told him not right now, may be later. He asked me why? I told him that I was busy. I felt bad and cried. For 29 years I kept the secret from my family and friends. I worked for different companies, and I thought that I could go on working and hiding the fact that I could not read. When my son asked me to read to him I relize that it was time to learn.

So a few day later I asked about some classes in reading. Some one informed me about a program that could help. I contacted the Center for Black Women's Wellness. The Center was founded in 1981 by Byllye Avery who is one of the board members. She is a hard working Black women and she wanted to make changes for other Black women. She did some research about other Black women and it was hard to find information on them so two years later in 1983 the first National Conference on Black women's health issues which brought together more than 1,500 womens across the country. The held a conference meeting at Spelman College in Atlanta, Georgia. They came in all types, forms, and ages. There were more than 60 work shops. They started a self-help group. A self-help group is when three or more women come together and talk about there self. At that time a 15 year old woman who spoke out and cried said she wasn't alone any more. She had been raped by her father, and no one knew that she had raised a daughter with the secret because she thought it was her fault.

On Jan. 1992 I started the program. By educating myself I can also help my children. I'm training to be a self developer. I hope to encourage more Black sisters to do what I am done attending the center is very inspiring.

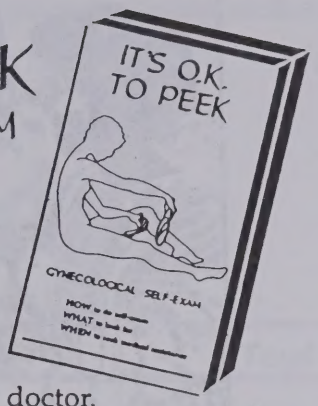
I have the opportunity to experience a lot of things that I thought I would never get a chance to do. I feel good about my self after getting involved in this program. The program has made me want to do more for myself.

Editor's Note: This article was left unedited. Reprint.



IT'S O.K. TO PEEK

GYNECOLOGICAL SELF-EXAM



A Video

HOW to do a self-exam,
WHAT to look for,
WHEN to take this information to your doctor.

For many women the vaginal tract, or "down there," remains a mystery, handed over to the care of a gynecologist. Self-exam helps women learn what's normal for their vaginal tract, and to be alert to any unusual changes.

Follow health consultant **Arabella Chavers-Julien** through a self-exam workshop conducted by **Sonja Avery, Terri Bailey** and **Traci Gilbert** for the National Black Women's Health Project.

"It is critical that every black woman learn to perform a gynecological self-exam. "IT'S O.K. TO PEEK" is a straightforward, easy-to-understand, tastefully produced tool to show women how."
Linda Villarosa, Editor
Body & Soul: The Black Women's Guide to Physical Health and Emotional Well-Being

"Informative, thought provoking and sometimes funny ... useful to health professionals and health educators who seek to clear up patients' misperceptions and make it plain."
Valerie Boyd, Editor-in-Chief
Health Quest: The Publication of Black Wellness

"A useful tool to become aware of your body and enable you to recognize changes early on so that appropriate medical intervention can take place.
Dr. Juaquita Callaway, Gynecologist

"The most wonderful representation of a self-help clinic I've ever seen. We love it, we want to use it!"
Dido Hasper, Founding Director
Chico Feminist Womens Health Center (CA)

A Sharp Show
26 Minutes

Produced and Directed by
Saundra Sharp

Self-exam is self-help tool used to detect changes in the vaginal tract that could signal a medical problem. Self-exam is not a replacement for GYN exam, Pap smears and regular diagnostic test.

Available Through:

National Black Women's Health Project (for individuals/home video only)
1211 Connecticut Ave., N.W. Suite 310, Washington, D.C. 20036 (202) 835-0117

Women Make Movies
462 Broadway #500-A, New York, NY 10013 (212) 925-0606

ON BECOMING A WOMAN

MOTHERS & DAUGHTERS "TALKING TOGETHER"

...About sexuality, motherhood, birth control and the many joys and sorrows of life

A film from the National Black Women's Health Project

This 104 minute presentation is available on 1/2" VHS cassette

Film making allows us to provide accurate information relevant to improving our lifestyles through a powerful medium. It captures our individual view and experiences, demonstrates our commonalties and provides a model for open, supportive communication between us. Seldom do we as Black women see ourselves portrayed positively or honestly in the media. Even less often, are we seen interacting in a way that contributes to our empowerment. It was the glaring absences of such portrayals that prompted the National Black Women's Health Project (NBWHP) to produce this film addressing issues of central importance to us while using the self-help approach. The issue of teen pregnancy, adolescent sexuality and reproductive health are particularly crucial in the focus of this film.

"On Becoming a Woman: Mothers and Daughters Talking Together," a 104-minute teen-pregnancy prevention film, was produced for the NBWHP by Atlanta film maker Cheryl Chisholm. As a documentary, it explores how mothers and daughters work to communicate openly and honestly with each other. It is the first film ever produced by Black women that explores female sexuality from the perspective of Black women. Based on a workshop designed in 1978 by NBWHP Founder Byllye Y. Avery, "On Becoming a Woman" is more than a sex information film. It is a film that pulls the viewers into the process of information-sharing on some difficult topics. A group of mothers, from variety of backgrounds, and their teenage daughters talk together about menstruation, sex, birth control, love, and why it is so hard for mothers and daughters to talk. The film is done in three parts, which could be viewed separately. On each of these days, one mother in the group leads. There are nervous giggles, laughter full of relief and shared understanding, moments of intense emotional revelation, and a lot of candid, lively talk.

The discussion of menstruation begins with mothers and daughters recalling their own menarche. Contrary to stereotypes, several women, both young and older, mention how proud and excited their mothers were about the event, and, in some cases, celebrated with their daughters. The section on sex begins with the mothers telling how they feel about bringing up sex with their daughters. A 24-minute animation covers male and female anatomy, reproduction, birth control methods and the risks and responsibilities of sex, including sex. The animation covers a lot of territory in a style that is both engaging and specific. The longest and most unusual part of the film records mother-and-daughter pairs talking about the things they never tell each other. Led by Lillie Allen, the women share self-doubts, fears, and love. The scenes are very moving, and you can't help admiring the risks and honesty involved as these down-to-earth women move gently toward new understanding.

Therefore, the film provides a model for parents on how to begin talking to their parents on how to begin talking to heir young persons about sexuality and reproduction. "On Becoming a Woman" is an engaging, compelling presentation that stimulates communication among the audience, reveals insights and lessens apprehension to talk about sex in public. "On Becoming a Woman" teaches and stimulates communication among mothers and daughters and encourages self help development in the communities. It also formulates a health attitude toward teenage sexuality and allows teens to gain a perspective that will empower them to take control of their lives, thus delaying sexual activity and prevention of pregnancy.

Order Today

	Price	Quantity	Total
On Becoming a Woman*	39.95		
It's OK To Peek*	28.00		
		Subtotal	
Add $5 Shipping/Handling per tape			
DC Residents add 6% Sales Tax			
		Total Enclosed	

Name_____

Address_____

City/State/Zip_____

Telephone_____

Method of Payment: All orders must be prepaid.

_____Check _____Money Order

Thank you!!

Please send completed form to:
National Black Women's Health Project (* For individuals/home video only)
1211 Connecticut Ave., NW Suite 310
Washington, DC 20036
Please Allow 4 - 5 weeks for delivery

Institutions/organizations contact:
Women Make Movies 462 Broadway #500-A New York, NY 10013 (212) 925-0606

®

Membership Application

Please Print

Name: _____

Home Address: _____

City/State/Zip Code: _____

Telephone ( ) _____

Self-Help Group/Chapter Affiliation: Yes/No Location: _____

Please check one:
□ Active □Need More Information

Membership Categories	Fee	Premiums
Basic	□$25	Membership card, educational data and newsletters
Supporting	□$50	Basic plus NBWHP newsmagazine, *Vital Signs*
Sustaining	□$100	Supporting plus NBWHP T-Shirt or Bag
Nonprofit Organization	□$250	*Vital Signs*
Sister Circle	□$1,000	Supporting premiums, plus NBWHP video - *It's O.K. to Peep* or *Body and Soul* book
Corporation	□$1,000	*Vital Signs*

Please mail your tax-deductible[1] membership in check or money order to:

National Black Women's Health Project
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1. NBWHP is a 501(c)3 charitable organization - all contributions are tax deductible to the extent allowed by law.

A Vital Vision

Vital Signs is a newsmagazine communicating health issues affecting women of African descent, their families and communities. Vital Signs is published by the National Black Women's Health Project, an organization committed to defining, promoting, and maintaining the physical, mental and emotional well-being of Black women.

The National Black Women's Health Project seeks to enable Black women to become aware of the nature of physical and mental health, and the relationship between the two, and to enable Black women to take control and become active participants in our health maintenance.

It is through a broadened concept of health and an active program to promote it that Black women can live, love and work in new and more authentic ways.

Health, for the National Black Women's Health Project, is not merely the absence of illness, but the active promotion of emotional, mental and physical wellness of this and future generations.

Such wellness is impossible without individual and group empowerment. Such personal and collective empowerment is essential to the redefining and reinterpretation of who Black women are, were and can become.

National Black Women's Health Project

VITAL SIGNS

Volume XI Issues I & II 1997

Publisher
The National Black Women's Health Project

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